💀 PBP Data Entry System - Section B-1, Contract X0001, Plan	001, Segment 000	_	
File Help Previous Next (Validate) Exit (No Validate)	Go To: #1a Inpatient Hospital-Acute - Base 1	T	
CLICK FOR DESCRIPTION OF BENEFIT         Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?         Yes         No         Select enhanced benefits:         Additional Days         Non-Medicare-covered Stay         Upgrades         Select type of benefit for Additional Days:         Mandatory         Optional         Is this benefit unlimited for Additional Days?         Yes         No, indicate number         Indicate number of Additional Days per benefit period:	Select type of benefit for Non-Medicare-covered stay:   Mandatory   Optional     Select type of benefit for Upgrades:   Mandatory   Optional		

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le Help Go To: Previous Next (Validate) Go To: Validate)	1a Inpatient Hospital-Acute - Base 2
Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Coinsurance? C Yes C No
O Yes O No Indicate the Maximum Enrollee Out-of-Pocket Cost amount:	Medicare-covered Coinsurance Cost Sharing for Tier 1: Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	C Yes C No
C Every two years C Every year C Every year C Every six months C Every three months	Indicate Coinsurance percentage for the Medicare-covered stay:
C Every Benefit Period C Every Stay C Other, Describe	<ul> <li>C Zero (No Coinsurance per Day)</li> <li>One</li> <li>C Two</li> <li>C Three</li> </ul>
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):
C Yes C No	Coinsurance% Interval 1 Begin Day Interval 1: End Day Interval 1:
How many cost sharing tiers do you offer?	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:
What is your lowest cost tier? C Tier 1 C Tier 2 C Tier 3	Coinsurance% Interval 3 Begin Day Interval 3: End Day Interval 3:

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Medicare-cove Do you charge charges for all Yes No Indicate C Indicate th Zero ( One Two Two Three Indicate th Medicare-	ered Coinsurance the Medicare-o services provid coinsurance per ne number of da No Coinsurance covered stay (e ice % Interval 1	ce Cost Sharing for tefined cost shar ed to the enrollee centage for the M y intervals for the e per Day) percentage and d s.g., 1 to 30; 31 to Begin Day Inter	or Tier 2: es? (These arrest in the inpatien ledicare-cover a Medicare-cov day interval(s) f 90): rval 1 End D	ed stay: eed stay: for the			
		Begin Day Inter					

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Medicare-covered Lifetime	Reserve Days	Tier 1	Medicare-	covered Lifetin	ie Reserve D	ays Tier 2	Medicare-o	covered Lifetime F	Reserve Days	Tier 3	
ndicate the number of day Medicare-covered Lifetime				e number of d covered Lifetir				e number of day i covered Lifetime f			
C Zero (No Coinsurance O One O Two C Three	e per Day)		C Zero ( C One C Two C Three	No Coinsuran	ce per Day)		C Zero (I C One C Two C Three	No Coinsurance p	per Day)		
ndicate the coinsurance p nterval(s) for the 60 Media Reserve Days (i.e., 1 - 60)	care-covered Lif		interval(s)	e coinsurance for the 60 Mec ays (i.e., 1 - 60	licare-covere		interval(s)	e coinsurance per for the 60 Medica ays (i.e., 1 - 60):			
	Interv	al Days			Interv	val Days			Interva	l Days	
Coinsurance %	Begin Day	End Day	С	oinsurance %	Begin Day	End Day		Coinsurance %	Begin Day	End Day	ŗ
nterval 1:			Interval 1:				Interval 1:				
nterval 2:			Interval 2:				Interval 2:				
nterval 3:			Interval 3:				Interval 3:				

Previous Next (Validate) Go To: #1a	Inpatient Hospital-Acute - Base 5
oes this plan's Additional Days cost sharing vary by hospital(s) in which an nrollee obtains care?	Additional Days Coinsurance Cost Sharing for Tier 2:
C Yes	Indicate the number of day intervals for Additional Days:
C No	C Zero (No Coinsurance per Day)
How many cost sharing tiers do you offer?	C One C Two
	C Three
What is your lowest cost tier?	Indicate the coinsurance percentage and day interval(s) for Additional
C Tier 1 C Tier 2	Days (enter "999" if unlimited days are offered; e.g., 91 to 999):
C Tier 3	Coinsurance% Interval 1 Begin Day Interval 1: End Day Interval 1:
ditional Days Coinsurance Cost Sharing for Tier 1:	
unional Days comsulance cost sharing for the fi	
	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:
Zero (No Coinsurance per Day)	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:
ndicate the number of day intervals for Additional Days: <sup>©</sup> Zero (No Coinsurance per Day) <sup>©</sup> One <sup>©</sup> Two	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:
C Zero (No Coinsurance per Day) O One	
<ul> <li>Zero (No Coinsurance per Day)</li> <li>One</li> <li>Two</li> <li>Three</li> <li>Indicate the coinsurance percentage and day interval(s) for Additional</li> </ul>	
C Zero (No Coinsurance per Day) C One C Two C Three Indicate the coinsurance percentage and day interval(s) for Additional	
C Zero (No Coinsurance per Day) C One C Two C Three Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):	
C Zero (No Coinsurance per Day) C One C Two C Three	
Ozero (No Coinsurance per Day)         One         Two         Three         Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):         Coinsurance % Interval 1         Begin Day Interval 1:	
<ul> <li>Zero (No Coinsurance per Day)</li> <li>One</li> <li>Two</li> <li>Three</li> <li>Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):</li> </ul>	
Coinsurance % Interval 1 Begin Day Interval 1:	

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File Help		
Previous Next (Validate) Go To Validate)	#1a Inpatient Hospital-Acute - Base 6	
Additional Days Coinsurance Cost Sharing for Tier 3: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance per Day) C One Two Three Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999): Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: C Coinsurance % Interval 3: C Coinsurance % Interval 3: C C C C C C C C C C C C C C C C C C C	Is the Coinsurance structure for the Non-Medicare-covered stay the same as the Coinsurance structure for the Medicare-covered stay?	Is the Coinsurance structure for Upgrades the same as the Coinsurance structure for the Medicare-covered stay?

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Previous Next (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 7		•	
If you do not have a service-specific deductible for this benefit but offer a plan-specific deductible, then enter the plan deductible in Section D. MA Organizations are not permitted to tier deductibles. Is there an enrollee Deductible? Yes No Indicate Deductible Amount for Tier 1: Medicare-covered Copayment Cost Sharing for Tier 1: Do you charge the Medicare-defined cost shares? (These are th for all services provided to the enrollee in the inpatient facility.) Yes No Indicate Deductible Amount for Tier 1:			
Indicate Deductible Amount for Tier 2: Indicate Deductible Amount for Tier 3: Indicate Deductible Amount for Tier 3: Indica	edicare-covered		
Is there an enrollee Copayment?  C Yes C No C No C Yes C No C Yes C No C Yes C	Day Interval 1: Day Interval 2: Day Interval 3:		

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e Help Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1a Inpatient Hospital-Acute - Bas	ie 8		•	
Medicare-cove	red Copaym	ient Cost Sharing for	Tier 2:		Medicare-covered Copayment C	ost Sharing for Tier 3:			
		e-defined cost share vided to the enrollee			Do you charge the Medicare-defi for all services provided to the en				
C Yes C No					C Yes C No				
	-	unt for the Medicare- intervals for the Medi	-		Indicate Copayment amount fo				
C Zero (No C O One C Two C Three	opayment p	er Day)			C Zero (No Copayment per D C One C Two C Three	Day)			
covered stay (e	e.g., 1 to 30;	ount and day interval 31 to 90): For more in w the variable help.			Indicate the copayment amoun stay (e.g., 1 to 30; 31 to 90): Fo please view the variable help.	or more information on c			
Copayment An	nt Interval 1	Begin Day Interval	1: End Day	Interval 1:	Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:		
Copayment An	nt Interval 2	Begin Day Interval	2: End Day	Interval 2:	Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:		
Copayment Am	nt Interval 3	Begin Day Interval	3: End Day	Interval 3:	Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:		
			_						

revious Next (Validat									
edicare-covered Lifetime Reserve Day:	s Tier 1	Medicare-co	overed Lifetime Re	eserve Day	rs Tier 2	Medicare-cov	vered Lifetime Res	erve Days Ti	er 3
dicate the number of day intervals for t overed Lifetime Reserve Days:	he Medicare-		number of day int time Reserve Day		the Medicare-		number of day inter ime Reserve Days		Medicare
Zero (No Copayment per Day) One Two Three	C Zero (No Copayment per Day) C One C Two C Three			C Zero (No Copayment per Day) O One O Two O Three					
dicate the copayment amount and day r the 60 Medicare-covered Lifetime Re: e., 1 - 60):	Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):				Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):				
Interv	al Days			Interv	val Days			Interva	l Days
Copay Amount Begin Day	End Day		Copay Amount	Begin Da	y End Day		Copay Amount	Begin Day	End Da
terval 1:		Interval 1:				Interval 1:			
terval 2:		Interval 2:				Interval 2:			
terval 3:		Interval 3:				Interval 3:			

Previous
Indicate the number of day intervals for Additional Days:       Indicate the number of day intervals for Additional Days:         C       Zero (No Copayment per Day)         O       One         O       Two         O       Three         Indicate the copayment amount and day interval(s) for Additional Days       Indicate the copayment amount and day interval(s) for Additional Days
Copayment Amt Interval 1       Begin Day Interval 1:       End Day Interval 1:       Copayment Amt Interval 1       Begin Day Interval 1:       End Day Interval 1:         Copayment Amt Interval 2       Begin Day Interval 2:       End Day Interval 2:       Copayment Amt Interval 2       Begin Day Interval 2:       End Day Interval 2:         Copayment Amt Interval 3       Begin Day Interval 3:       End Day Interval 3:       Copayment Amt Interval 3       Begin Day Interval 3:       End Day Interval 3:         Copayment Amt Interval 3       Begin Day Interval 3:       End Day Interval 3:       Copayment Amt Interval 3       Begin Day Interval 3:       End Day Interval 3:

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- Previous	Next	Exit (Validate)	Exit (No Validate)	#1a Inpatient Hospital-Acute - Base 11	
	mber of day i	Cost Sharing for Ti ntervals for Addition er Day)		Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay?	
◯ Three ndicate the co	inlimited day	ount and day interva is are offered; e.g., 9 Begin Day Interva		Indicate the number of day intervals for the Non-Medicare-covered stay:          C       Zero (No Copayment per Day)         O       One         C       Two         C       Three	
Copayment Am Copayment Am		Begin Day Interva		Indicate the copayment amount and day interval(s) for the Non-Medicare- covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999): Copayment Amt Interval 1Begin Day Interval 1: End Day Interval 1:	
zo payment Am			3: End Day Interval 3:	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	
				Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	

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structure for th Yes No Indicate Co Indicate Co Indicate Co Vhat is your In Original M Original M Original M Other, Des If "Other, Des If "Other, Des If "Other, Des If "Other, Des No Is authorization O Yes No	e Medicare-co	unt for Upgrades p unt for Upgrades p ital-Acute benefit p	er stay: er day: eriod? tion below:	ayment	Inpatient Hospital-Acute Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:

revious Next (Validate)	Go To: #1a Inpatient Hospital-Acute (B Only) - Base 1
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes No Indicate Maximum Plan Benefit Coverage amount:
Select type of benefit for Inpatient Hospital-Acute Services: Mandatory Optional Does this benefit have unlimited days?	Select Maximum Plan Benefit Coverage periodicity: C Every three years Every two years Every year Every six months Every three months Every Benefit Period Every Stay
○ Yes ○ No, indicate number Indicate number of days per period:	C Other, Describe
Select the days periodicity: C Every three years	
<ul> <li>Every two years</li> <li>Every year</li> <li>Every six months</li> <li>Every three months</li> <li>Every Benefit Period</li> </ul>	
C Every Stay C Other, Describe	

revious Next (Validate) Go To:	#1a Inpatient Hospital-Acute (B Only) - Base 2	
there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No	Indicate the number of day intervals for the stay:	
ndicate the Maximum Enrollee Out-of-Pocket Cost amount:	O Two O Three Indicate the coinsurance percentage and day interval(s) for the stay	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	(enter "999" if unlimited days are offered; e.g., 1 to 999): Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:	
C Every two years C Every year C Every six months C Every three months C Every Benefit Period	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	
C Every Stay C Other, Describe	Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	
there an enrollee Coinsurance? Yes No		
ndicate Coinsurance percentage per stay:		

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File Help Previous Next	Exit (Validate)	Exit (No Validate)	Go To:	#1a Inpatient Hospital-Acute (B Only) - Base 3		
Is there an enrollee Deduct Yes No Indicate Deductible Amo Is there an enrollee Copayn Yes No Indicate Copayment am Indicate the number of d Zero (No Copaymen One Two Three	unt: nent? ount per stay: ay intervals for the :	stay:		Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999): Copayment Amt Interval 1 Begin Day Interval 1: Copayment Amt Interval 2 Begin Day Interval 2: Copayment Amt Interval 3 Begin Day Interval 3: Copayment Amt Interval 3 Begin Day Interval 3: No	Is authorization required?  Yes Yes No No	

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1a Inpat	ient Hospital	-Acute (B Onl	y) - Base 4		•	]	
Inpatient Hospi	ital-Acute Note	es										
Note may includ	de additional i	nformation to des	cribe benefit in t	his service (	category. D	o notrepea	tinformation	captured in d	ata entry.			
Notes:										~		
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	#1b Inpatient Hospital Psychiatric - Base 1
CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C? Ves No Select enhanced benefit:	Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Select the Maximum Enrollee Out-of-Pocket Cost type:
Additional Days Non-Medicare-covered Stay Select type of benefit for Additional Days: C Mandatory C Optional	C Covered under Inpatient Hospital Services Category 1a Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select the Maximum Enrollee Out-of-Pocket Cost periodicity:
Is this benefit unlimited for Additional Days?  O Yes O No, indicate number Indicate number of Additional Days per benefit period:	<ul> <li>Every three years</li> <li>Every two years</li> <li>Every year</li> <li>Every six months</li> <li>Every three months</li> <li>Every Benefit Period</li> <li>Every Stay</li> <li>Other, Describe</li> </ul>
Select type of benefit for Non-Medicare-covered stay:      Mandatory      Optional	

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segmen	t 000 — 🗆 ×
le Help Previous Next (Validate) Validate) Go To:	#1b Inpatient Hospital Psychiatric - Base 2
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?          Yes         No         How many cost sharing tiers do you offer?         Tier 1         Tier 2         Tier 3	Medicare-covered Coinsurance Cost Sharing for Tier 1:         Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)         Yes         No         Indicate Coinsurance percentage for the Medicare-covered stay:         Indicate the number of day intervals for the Medicare-covered stay:         Zero (No Coinsurance per Day)         One         Three         Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay:         Coinsurance % Interval 1         Begin Day Interval 1:         End Day Interval 2:         End Day Interval 3:         End Day Interval 3:

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revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1b Inpatient Hospital Psychiatric - Base 3	•	
edicare-covere	d Coinsuran	ce Cost Sharing fo	or Tier 2:		Medicare-covered Coinsurance Cost Sharing for Tier 3:		
		defined cost share led to the enrollee			Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)		
D Yes D No					C Yes C No		
Indicate Coi	nsurance per	centage for the M	edicare-cover	ed stay:	Indicate Coinsurance percentage for the Medicare-covered stay:		
Indicate the	number of da	y intervals for the	Medicare-cov	vered stay:	Indicate the number of day intervals for the Medicare-covered stay:		
C Zero (No C One C Two	o Coinsuranc	e per Day)			<ul> <li>Zero (No Coinsurance per Day)</li> <li>One</li> <li>Two</li> </ul>		
C Three	coinsurance	percentage and d	ay interval(s)	forthe	O Three Indicate the coinsurance percentage and day interval(s) for the		
		e.g., 1 to 30; 31 to			Medicare-covered stay (e.g., 1 to 30; 31 to 90):		
Coinsurance	e % Interval 1	Begin Day Inter	val 1: End D	ay Interval 1:	Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:		
Coinsurance	e % Interval 2	Begin Day Inter	val 2: End D	ay Interval 2:	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:		
Coinsurance	e % Interval 3	Begin Day Inter	val 3: End D	ay Interval 3:	Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:		

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Previous Next (Validate)		se 4					
Medicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3					
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:					
C Zero (No Coinsurance per Day) C One C Two C Three	<ul> <li>C Zero (No Coinsurance per Day)</li> <li>O One</li> <li>C Two</li> <li>C Three</li> </ul>	C Zero (No Coinsurance per Day) C One C Two C Three					
Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):					
Interval Days	Interval Days	Interval Days					
Coinsurance % Begin Day End Day	Coinsurance % Begin Day End Day	Coinsurance % Begin Day End Day					
Interval 1:	Interval 1:	Interval 1:					
Interval 2:	Interval 2:	Interval 2:					
Interval 3:	Interval 3:	Interval 3:					

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revious Next (Validate) Go To: #1b	Inpatient Hospital Psychiatric - Base 5
oes this plan's Additional Days cost sharing vary by hospital(s) in which an prollee obtains care?	Additional Days Coinsurance Cost Sharing for Tier 2:
) Yes	Indicate the number of day intervals for Additional Days:
No How many cost sharing tiers do you offer?	C Zero (No Coinsurance per Day) C One C Two C Three
What is your lowest cost tier? O Tier 1 O Tier 2 O Tier 3	Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999): Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:
dditional Days Coinsurance Cost Sharing for Tier 1: dicate the number of day intervals for Additional Days: Zero (No Coinsurance per Day)	Coinsurance% Interval 2 Begin Day Interval 2: End Day Interval 2:
0 One 0 Two 0 Three	Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:
ndicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):	
Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:	
Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	

Help					
revious Next	Exit (Validate)	Go T Exit (No Validate)	o: #1b Inpatient Hospital Psychiatric - Base 6	•	
dditional Days Coinsurance	e Cost Sharing for T	ier 3:	Is the Coinsurance structure for the Non-Medicare-covered stay the same as the Coinsurance structure for the Medicare-covered stay?		
dicate the number of day in Zero (No Coinsurance p One		al Days:	C Yes C No		
) Two ) Three			Indicate Coinsurance percentagefor the Non-Medicare-covered stay:		
ndicate the coinsurance pe Days (enter "999" if unlimite Coinsurance % Interval 1 E Coinsurance % Interval 2 E Coinsurance % Interval 3 E	d days are offered; Begin Day Interval 1 Begin Day Interval 2	e.g., 91 to 999): : End Day Interval 1: : End Day Interval 2:	Indicate the number of day intervals for the Non-Medicare-covered stay:          O       Zero (No Coinsurance per Day)         O       One         O       Two         O       Three         Indicate the coinsurance percentage and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999):		
			Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:		
			Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:		

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File Help		
Previous Next (Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 7	•	
If you do not have a service-specific deductible for this benefit but offer a plan-specific deductible, then enter the plan deductible in Section D.   MA Organizations are not permitted to tier deductibles.   Is there an enrollee Deductible?   Yes   No   Indicate Deductible Amount for Tier 1:   Indicate Deductible Amount for Tier 2:   Indicate Deductible Amount for Tier 3:   Indicate Deductible Amount for Tier 3:   Indicate Deductible Amount for Tier 3:   Conswment Amt Interval 1   Conswment Amt Interval 1 Design Daw Interval 1		
Is there an enrollee Copayment?       Copayment Amt Interval 1       Begin Day Interval 1:       End Day Interval 1:         No       Copayment Amt Interval 2       Begin Day Interval 2:       End Day Interval 2:         Copayment Amt Interval 3       Begin Day Interval 3:       End Day Interval 2:		

	4		PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000 ile Help							
Next	Exit	Exit (No Validate)	Go To:	#1b Inpatient Hospital Psychiatric - Base 8	<b>-</b>					
red Copaym	ent Cost Sharing for Ti	er 2:		Medicare-covered Copayment Cost Sharing for Tier 3:						
				Do you charge the Medicare-defined cost shares? (These are the total cha for all services provided to the enrollee in the inpatient facility.)	rges					
				O Yes O No						
nber of day opayment p payment am: .g., 1 to 30; :	intervals for the Medica er Day) ount and day interval(s) 31 to 90): For more info w the variable help.	re-covered sta	are- ost	stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitatio please view the variable help.	ns					
t Interval 2	Begin Day Interval 2:	End Day Inte	erval 2:	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interv	al 2:					
t Interval 3	Begin Day Interval 3:	End Day Inte	erval 3:	Copayment Amt Interval 3 Begin Day Interval 3: End Day Interv	al 3:					
	ervices pro	ervices provided to the enrollee in a syment amount for the Medicare-co- mber of day intervals for the Medicar opayment per Day) exayment amount and day interval(s; g.g., 1 to 30; 31 to 90): For more infors s please view the variable help. t Interval 1 Begin Day Interval 1: t Interval 2 Begin Day Interval 2:	ervices provided to the enrollee in the inpatient fa	nber of day intervals for the Medicare-covered stay: opayment per Day) bayment amount and day interval(s) for the Medicare- g., 1 to 30; 31 to 90): For more information on cost s please view the variable help.	ervices provided to the enrollee in the inpatient facility.)       for all services provided to the enrollee in the inpatient facility.)         or all services provided to the enrollee in the inpatient facility.)       Yes         No       Indicate Copayment amount for the Medicare-covered stay:         Indicate Copayment amount for the Medicare-covered stay:       Indicate the number of day intervals for the Medicare-covered stay:         Indicate the number of day intervals for the Medicare-covered stay:       Indicate the number of day intervals for the Medicare-covered stay:         opayment per Day)       O ne       Two         or Two       Three         indicate the copayment amount and day interval(s) for the Medicare-covered stay:       Indicate the copayment amount and day interval(s) for the Medicare-covered stay:         opayment amount and day interval(s) for the Medicare-covered stay:       Indicate the copayment amount and day interval(s) for the Medicare-covered stay:         opayment amount and day interval(s) for the Medicare-covered stay:       Indicate the copayment amount and day interval(s) for the Medicare-coveres tay (e.g., 1 to 30; 31 to 90): For more information on cost share limitation please view the variable help.         tilnterval 1       Begin Day Interval 1:       End Day Interval 1:         copayment Amt Interval 1       Begin Day Interval 2:       End Day Interval 2:         tilnterval 2       Begin Day Interval 2:       End Day Interval 2:	ervices provided to the enrollee in the inpatient facility.)       for all services provided to the enrollee in the inpatient facility.)         or yes       No         number of day intervals for the Medicare-covered stay:       Indicate Copayment amount for the Medicare-covered stay:         indicate the number of day intervals for the Medicare-covered stay:       Indicate the number of day intervals for the Medicare-covered stay:         indicate the number of day intervals for the Medicare-covered stay:       Zero (No Copayment per Day)         indicate the copayment amount and day interval(s) for the Medicare-covered stay:       Three         indicate the copayment amount and day interval(s) for the Medicare-covered stay:       Indicate the copayment amount and day interval(s) for the Medicare-covered stay:         indicate the copayment amount and day interval(s) for the Medicare-covered stay:       Indicate the copayment amount and day interval(s) for the Medicare-covered stay:         indicate the copayment amount and day interval(s) for the Medicare-covered stay:       Indicate the copayment amount and day interval(s) for the Medicare-covered stay:         indicate the copayment amount and day interval(s) for the Medicare-covered stay:       Indicate the copayment amount and day interval(s) for the Medicare-covered stay:         indicate the copayment amount and day interval 1:       End Day Interval 1:       End Day Interval 1:         indicate the copayment Amt Interval 1       Begin Day Interval 1:       End Day Interval 2:         indicat	ervices provided to the enrollee in the inpatient facility.)       for all services provided to the enrollee in the inpatient facility.)			

CY2022 PBP – Section B 12/02/2020 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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Previous Next (Validate	Exit (No ) Validate)	0010	: #1b Inpatient H	lospital Psyci	name - Dase o			<b>_</b>	
Medicare-covered Lifetime Reserve Days	Tier1 M	ledicare-co	overed Lifetime Re	eserve Days	Tier 2	Medicare-cov	vered Lifetime Res	erve Days T	ïer 3
Indicate the number of day intervals for th covered Lifetime Reserve Days:	e Medicare- In	dicate the overed Life	number of day int etime Reserve Day	tervals for th ys:	e Medicare-	Indicate the n covered Lifet	umber of day inter me Reserve Days	vals for the	Medi
C Zero (No Copayment per Day) C One C Two C Three		C Zero (N C One C Two C Two C Three	o Copayment per	Day)		C Zero (No C One C Two C Three	Copayment per D	ay)	
Indicate the copayment amount and day ir for the 60 Medicare-covered Lifetime Rese (i.e., 1 - 60):	erve Days fo		copayment amou edicare-covered l				opayment amount dicare-covered Lif		
Interva	I Days			Interva	l Days			Interva	al Day
Copay Amount Begin Day	End Day		Copay Amount	Begin Day	End Day		Copay Amount	Begin Day	En
Interval 1:	Ir	nterval 1:				Interval 1:			
Interval 2:	Ir	nterval 2:				Interval 2:			
Interval 3:	Ir	nterval 3:				Interval 3:			



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Previous Next	Exit (Validate)	Go To: Exit (No Validate)	#1b Inpatient Hospital Psychiatric	- Base 10		•	
Additional Days Copayment Indicate the number of day C Zero (No Copayment) O One O Two O Three Indicate the copayment arr (enter "999" if unlimited day	intervals for Additional per Day) nount and day interval(s	Days:	Additional Days Copayment Indicate the number of day i C Zero (No Copayment pr O One Two O Three Indicate the copayment amove (enter "999" if unlimited day	ntervals for Additional D er Day) ount and day interval(s) f	ays: for Additional Days		
Copayment Amt Interval 1 Copayment Amt Interval 2	Begin Day Interval 2	: End Day Interval 1:	Copayment Amt Interval 2	Begin Day Interval 1: Begin Day Interval 2:	End Day Interval 2:		
Copayment Amt Interval 3	Begin Day Interval 3	End Day Interval 3:	Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:		

revious Next		ixit (No alidate)	#1b Inpatient Hospital Psychiatric - Base 11	<b>-</b>	
Iditional Days Copaymen	t Cost Sharing for Tier 3:		Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay?		
dicate the number of day i		ays:	C Yes C No		
One Two Three			Indicate Copayment amount for the Non-Medicare-covered stay:		
ndicate the copayment am enter "999" if unlimited day			Indicate the number of day intervals for the Non-Medicare-covered stay:		
opayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:	C Zero (No Copayment per Day) C One C Two C Three		
opayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:	Indicate the copayment amount and day interval(s) for the Non-Medicare- covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999):		
opayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:	Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:		
			Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:		
			Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:		

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1b Inpatient Hospital Psychiatric - Base 12
C Original Me C Annual C Per Admiss C Other, Des If "Other, De Do you charge C Yes C No Is authorization C Yes C No	edicare sion or Per St cribe escribe" is sele cost sharing n required?	tal Psychiatric ben ay ected enter descrip on the day of disch	ntion below:	5?	Inpatient Hospital Psychiatric Notes Note may include additional information to describe benefit in this service category. Do not reperinformation captured in data entry. Notes:

💀 PBP Data En	try System - S	ection B-1, Contra	act X0001, Plan	001, Segm	ent 000	_	$\times$
<u>F</u> ile <u>H</u> elp							
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1b Inpatient Hospital Psychiatric (B Only) - Base 1	<b>.</b>	
CLICK FOR	DESCRIPTIO	N OF BENEFIT			Is there a service-specific Maximum Plan Benefit Coverage amount?		
					O No		
Do you offer In	patient Psychi	atric Hospital Serv	ices as a benef	it?			
C Yes	panoner byon				Select the Maximum Plan Benefit Coverage type:		
C No					C Covered under Inpatient Hospital Services Category 1a		
					C Plan-specified amount per period		
Select type o C Mandato C Optional	ry	patient Psychiatric	Hospital Servic	es:	Indicate Maximum Plan Benefit Coverage amount:		
Does this be	nefit have unlir	mited days?			Select Maximum Plan Benefit Coverage periodicity:		
C Yes					C Every three years		
C No, india	cate number				C Every two years C Every year		
					O Every six months		
Indicate nu	umber of days p	perperiod:			C Every three months		
					C Every Benefit Period		
					C Every Stay		
	e days periodi	city:			O Other, Describe		
	y three years						
O Ever	y two years						
	y year y six months						
	y three months						
	y Benefit Perio						
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	r, Describe						
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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1b Inpatient Hospital Psychiatric (B Only) - Base 2	•	[	
Is there a servi	ce-specific Ma	aximum Enrollee C	ut-of-Pocket Co	ost?				
C Yes C No								
Select the Max	ximum Enrolle	ee Out-of-Pocket C	Cost type:					
C Covered u C Plan-spec		atient Hospital Serv per period	vices Category	1a				
		e Out-of-Pocket C	ost amount:					
Select the M	faximum Enro	llee Out-of-Pocke	t Cost periodicit	y:				
C Every th C Every to								
C Every y	ear							
C Every s C Every th	ix months hree months							
C Every B	enefit Period							
C Every S C Other, I								
O Other, I	Jescribe							

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Previous Next	Exit Exit (N (Validate) Validate		<b>_</b>	
Is there an enrollee Coinsuran          Yes         No         Indicate Coinsurance percer         Indicate the number of day in         Zero (No Coinsurance percer         One         Two         Three	tage per stay: tervals for the stay:	Indicate the coinsurance percentage and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999): Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:		

BP Data Entry System - Section B-1, Contract X0001, Plan 001, Segr	nent 000	- 🗆 ×
File Help Previous Next (Validate) File Help Exit (No Validate) Go To Exit (No Validate)	#1b Inpatient Hospital Psychiatric (B Only) - Base 4	
Is there an enrollee Deductible?  Yes No Indicate Deductible Amount:  Sthere an enrollee Copayment?  Yes No Indicate Copayment amount per stay: Indicate Copayment amount per stay: Indicate the number of day intervals for the stay: C Zero (No Copayment per Day) One Two Three	Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999): Copayment Amt Interval 1 Begin Day Interval 1: Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2: Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3: Do you charge cost sharing on the day of discharge? Yes No	Is authorization required?         Yes         Yes         No

System - Section	B-1, Contract X0	001, Plan 00	)1, Segm	ent 000							-		$\times$
Next (Va	Exit Ex lidate) Val	cit (No	Go To:	#1b Inpa	atient Hosp	oital Psych	iatric (B On	nly) - Base S	5			•	
Psychiatric Notes													
dditional informa	tion to describe b	enefit in this	servicec	ategory. [	Do not rep	peatinforr	mation cap	tured in dat	a entry.				
											~		
	Next (Va Psychiatric Notes	Next (Validate) Va	Next (Validate) Psychiatric Notes	Next (Validate) Go To: Vext (Validate) Validate)	Exit Exit (No Next (Validate) Validate) Psychiatric Notes	Next (Validate) Go To: #1b Inpatient Hosp Validate)	Next (Validate) Go To: #1b Inpatient Hospital Psych Validate)	Kext     Kexit     Exit (No Validate)     Go To:     #1b Inpatient Hospital Psychiatric (B Or Validate)       Psychiatric Notes	Kext       Kext       Kext       Go To:       #1b Inpatient Hospital Psychiatric (B Only) - Base 5         Next       (Validate)       Validate)	Exit     Exit (No       Vext     Validate)   Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 5	Image: Next       Image: Exit (No Validate)       Go To:       #1b Inpatient Hospital Psychiatric (B Only) - Base 5         Psychiatric Notes       Psychiatric Notes	Image: Next       Image: Exit (No Validate)       Go To:       #1b Inpatient Hospital Psychiatric (B Only) - Base 5         Psychiatric Notes       Psychiatric Notes	Next       Exit (Validate)       Go To:       #1b Inpatient Hospital Psychiatric (B Only) - Base 5         Psychiatric Notes

#2 SNF – Base 1

💀 PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment	- 000	_	$\times$
File Help Previous Next (Validate) Go To:	2 SNF - Base 1	•	
CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C? O Yes O No Select enhanced benefits: Additional days beyond Medicare-covered Non-Medicare-covered stay (MMP Only)	Do you allow less than 3 day inpatient hospital stay prior to SNF admission? Yes No Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2): Zero One Two		
Select type of benefit for Additional Days beyond Medicare-covered:          O       Mandatory         O       Optional         Is this benefit unlimited for Additional Days?         O       Yes	Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
C No, indicate number Indicate the number of Additional Days beyond Medicare-covered per benefit period:	C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	]	
Select type of benefit for the Non-Medicare-covered stay: C Mandatory C Optional	Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years C Every year C Every six months C Every three months C Every Stay C Other, Describe		

### #2 SNF – Base 2

revious Next	Exit (Validate)	Exit (No Validate)	Go To: 📕	¥2 SNF - Base 2 ▼
oes this plan's Medicare-co ursing Facility in which an Yes No How many cost sharing tie What is your lowest cost tie Tier 1 Tier 2 Tier 3	enrollee obtains ca rs do you offer?		y the Skilled	Is there an enrollee Coinsurance?

### #2 SNF – Base 3

🖳 PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Se	egment 000 — 🗆 🗙
File Help Previous Next (Validate) Go Validate)	To: #2 SNF - Base 3
Medicare-covered Coinsurance Cost Sharing for Tier 2:	Medicare-covered Coinsurance Cost Sharing for Tier 3:
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)
C Yes C No	O Yes O No
Indicate Coinsurance percentage for the Medicare-covered stay:	Indicate Coinsurance percentage for the Medicare-covered stay:
Indicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:
C Zero (No Coinsurance per Day) C One C Two	<ul> <li>C Zero (No Coinsurance per Day)</li> <li>O One</li> <li>O Two</li> </ul>
C Two C Three	C Three
Indicate the coinsurance percentage and day interval(s) for Medicare- covered stay (e.g.; 1 to 20; 21 to 100):	Indicate the coinsurance percentage and day interval(s) for Medicare- covered stay (e.g.; 1 to 20; 21 to 100):
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval	1: Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval	2: Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval	3: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:

🚪 PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 0 ile Help	- 000	×
Previous Next (Validate) Go To: #23	SNF - Base 4	
Does this plan's Additional Days cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	Additional Days Coinsurance Cost Sharing for Tier 2: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance per Day) C One Two Three Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999): Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	

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e Help				
Previous N	lext (	Exit (Validate)	Exit (No Validate)	p: #2 SNF - Base 5
Days (enter "999" i Coinsurance % In Coinsurance % In	of day interva urance per Day funlimited day terval 1: Begi terval 2: Begi	Ils for Additional y) tage and day inte ys are offered; e. in Day Interval 1:	Days: erval(s) for Additional	Indicate the number of day intervals for the Non-Medicare-covered stay: C Zero (No Coinsurance per Day) O One Two Two Three Indicate the coinsurance percentage and day interval(s) for the Non- Medicare-covered stay (enter "999" if unlimited days are offered; e.g., 1 to 999):

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🖳 PBP Data Entry System - Section B-2, Contract X	X0001, Plan 001, Seg	gment 000 — 🗆 🖄
	X Go To Exit (No Validate)	o: #2 SNF - Base 6
If you do not have a service-specific deductible for the offer a plan-specific deductible, then enter the plan of Section D. MA Organizations are not permitted to tier deductible. Is there an enrollee Deductible?          Yes         No         Indicate Deductible Amount Tier 1:         Indicate Deductible Amount Tier 2:         Indicate Deductible Amount Tier 3:	deductible in	Is there an enrollee Copayment?          Yes         No         Medicare-covered Copayment Cost Sharing for Tier 1:         Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)         Yes         No         Indicate Copayment amount for Medicare-covered stay:         Indicate the number of day intervals for the Medicare-covered stay:         Careo (No Copayment per Day)         One         Two         Indicate the copayment amount and day interval(s) for Medicare-covered stay:         Copayment Amount and day interval 1:         Endicate the copayment amount and day interval 1:         Endicate the copayment amount and day interval 2:         Endicate the copayment amount and day interval 3:         End Day Interval 1:         Copayment Amt Interval 2:         Begin Day Interval 2:         End Day Interval 2:         Copayment Amt Interval 3:         Begin Day Interval 3:

🔜 PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segn	nent 000 —	
File Help		
Previous Next (Validate) Go To: Validate)	#2 SNF - Base 7	
Medicare-covered Copayment Cost Sharing for Tier 2:	Medicare-covered Copayment Cost Sharing for Tier 3:	
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)	
C Yes C No	O Yes O No	
Indicate Copayment amount for Medicare-covered stay:	Indicate Copayment amount for Medicare-covered stay:	
Indicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No Copayment per Day) C One C Two C Three	C Zero (No Copayment per Day) C One C Two C Three	
Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g.; 1 to 20; 21 to 100): For more information on cost share limitations please view the variable help.		
Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	

Help	
revious Next (Validate) Go To:	¥2 SNF - Base 8
dditional Days Copayment Cost Sharing for Tier 1:	Additional Days Copayment Cost Sharing for Tier 2:
dicate the number of day intervals for Additional Days:	Indicate the number of day intervals for Additional Days:
C Zero (No Copaymentper Day) C One C Two C Three	C Zero (No Copayment per Day) C One C Two C Three
Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999):	Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999):
Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:

evious Next	Exit (Validate)	Exit (No Validate)	Go To: 🏼	≠2 SNF - Base 9
ditional Days Copayment C	ost Sharing for T	ier 3:		Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay?
licate the number of day int Zero (No Copayment per		nal Days:		O Yes O No
One Two Three				Indicate Copayment amount for Non-Medicare-covered stay:
ndicate the copayment amo enter "999" if unlimited days			onal Days	Indicate the number of day intervals for the Non-Medicare-covered stay:
opayment Amt Interval 1:	Begin Day Inter	val 1: End Day	/ Interval 1:	C Zero (No Copayment per Day) C One C Two C Three
opayment Amt Interval 2:	Begin Day Inter	val 2: End Day	/ Interval 2:	Indicate the copayment amount and day interval(s) for the Non-Medicare- covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999):
opayment Amt Interval 3:	Begin Day Inter	val 3: End Day	/Interval 3:	Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:
				Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
				Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:

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File Help Previous Next (Validate) Go To: #2 SNI (Validate) What is your SNF benefit period? Original Medicare Annual	
O Original Medicare	
O Per Admission or Per Stay     O Other, Describe     If "Other, Describe" is selected enter description below:	SNF Notes Note may include additional information to describe benefit in this service category. Do not repea information captured in data entry. Notes:
Do you charge cost sharing on the day of discharge?  C Yes No Is authorization required? C Yes No Is a referral required for SNF Services? C Yes	
C No	

Help			
revious Next (Validate) Validate	Go To: #2 SNF (B Only) - Base 1 o e)	<b>•</b>	
CLICK FOR DESCRIPTION OF BENEFIT	Do you allow less than 3 day Inpatient hospital stay prior to SNF admission?		
oyou offer SNF Care as a benefit?	C Yes C No		
) Yes ) No	Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):		
Select type of benefit for SNF Care:	C Zero C One C Two		
O Mandatory O Optional			
Does this benefit have unlimited days?	Is there a service-specific Maximum Plan Benefit Coverage amount?		
○ Yes ○ No, indicate number	O Yes O No		
Indicate number of days per period:	Indicate Maximum Plan Benefit Coverage amount:		
Select the days periodicity:	Select Maximum Plan Benefit Coverage periodicity:		
C Every three years C Every two years C Every year	C Every three years C Every two years C Every year		
C Every six months Every three months	C Every six months Every three months		
C Every Stay C Other, Describe	C Every Stay C Other, Describe		

😸 PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000	- 🗆 X
File Help Previous Next (Validate) Exit (No Validate) Validate) Go To: #2 SNF (B Only) - Base 2	<b>_</b>
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?       Indicate the number of day intervals for the stay:         Yes       Circle         Indicate amount for Maximum Enrollee Out-of-Pocket Cost:       Circle         Indicate the number of day intervals for the stay:       Circle         Select the Maximum Enrollee Out-of-Pocket Cost periodicity:       Circle         Every three years       Coinsurance % Interval 1         Every three years       Coinsurance % Interval 2         Every three months       Coinsurance % Interval 2         Every three months       Coinsurance % Interval 3         Begin Day Interval 3:       End I         Is there an enrollee Coinsurance?       Coinsurance % Interval 3         Yes       No         Indicate Coinsurance percentage:       Mo	Day Interval 1: Day Interval 2:

💀 PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000 File Help	_		×
Previous Next (Validate) Exit (No Validate) Go To: #2 SNF (B Only) - Base 3		•	
Is there an enrollee Deductible?     Yes   Indicate the copayment amount and day interval(s) for the suminited days are offered; e.g., 1 to 999):   Opayment Amt Interval 1   Begin Day Interval 1: End Day   Copayment Amt Interval 2   Begin Day Interval 2: End Day   Copayment Amt Interval 3   Begin Day Interval 3: End Day   Copayment Amt Interval 3   Begin Day Interval 3: End Day   Copayment Amt Interval 3   Begin Day Interval 3: End Day   Copayment Amt Interval 3   Begin Day Interval 3: End Day   Copayment Amt Interval 3   Begin Day Interval 3: End Day   Copayment Amt Interval 3   Begin Day Interval 3: End Day   Indicate the number of day intervals for the stay:   Cone   Two   Three	/ Interval 1: / Interval 2:		

Help	try System - S	ection B-2, Cont	ract X0001, Pla	n 001, Segmen	t 000			_		
revious	Next	Exit (Validate)	Exit (No Validate)	Go To: 📕	2 SNF (B Only)	- Base 4		•	]	
authorizatio	n required?									
ੇ Yes ∂No										
	uired for SNF	Services?								
) Yes ) No										
cilled Nursing	) Facility (B-On	Iv) Notes								
ote may inclu	de additional ir	nformation to des	cribe benefit in t	his service						
ategory. Do n otes:	ot repeat inforr	mation captured in	n data entry.							
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PBP Data Ent Help	ry system - S	ection B-3, Contr	act X0001, Plar	n uu1, Segm	ent 000 — 🗆
revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	#3 Cardiac and Pulmonary Rehabilitation Services - Base 1
	rovide Cardia	ac and Pulmonary i	Rehabilitation :	Services as a	Select type of benefit for Additional Pulmonary Rehabilitation Services:
C Yes	enefit under F	Part C?			O Optional
C No Select enhand	ced benefit:				Is this benefit unlimited for Additional Pulmonary Rehabilitation Services?
Additional Additional	Intensive Car Pulmonary R Supervised E	abilitation Services diac Rehabilitation ehabilitation Servic exercise Therapy ( se (PAD) Services	ces	omatic	No, indicate number     Indicate number of visits for Additional Pulmonary Rehabilitation Services:     Select the Additional Pulmonary Rehabilitation Services periodicity:
Peripheral Artery Disease (PAD) Services Select type of benefit for Additional Cardiac Rehabilitation Services:     O Mandatory     O Optional				ervices:	C Every three years C Every two years C Every year C Every six months
Is this benefit u C Yes C No, indica		dditional Cardiac	Rehabilitation :	Services?	C Every three months C Other, Describe Select type of benefit for Additional Supervised Exercise Therapy (SET) for
Indicate	number of vis	its for Additional C	ardiac Rehabil	itation Servio	es: Symptomatic Peripheral Artery Disease (PAD) Services: C Mandatory
Select the Additional Cardiac Rehabilitation Services periodicity: C Every three years C Every two years C Every year C Every six months C Every three months		s periodicity:	Optional     Is this benefit unlimited for Additional Supervised Exercise Therapy (SET) for     Symptomatic Peripheral Artery Disease (PAD) Services?     Yes     No, indicate number     Indicate number     (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:		
	ther, Describ enefit for Add	e litional Intensive C	ardiac Rehabil	itation Servi	es:
C Mandatory C Optional					Select the Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services periodicity:
Is this benefit unlimited for Additional Intensive Cardiac Rehabilitation Services' C Yes C No. indicate number				abilitation Se	vices? C Every three years C Every two years C Every year C Every six months
		r Additional Intens	ive Cardiac Re	habilitation S	C Every three months
C Ever C Ever C Ever C Ever C Ever	ry three years ry two years		Rehabilitation S	Services peri	odicity:

💀 PBP Data Entry System - Section B-3, Contract X0001, Plan 001, Segme	nt 000		-		$\times$
File Help					
Previous Next (Validate) Go To:	#3 Cardiac and Pulmonary Rehabilitation Services - Base 2		-		
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Select which Cardiac and Pulmonary Rehabilitation Servic	ces have a			
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Coinsurance (Select all that apply): Medicare-covered Cardiac Rehabilitation Services Medicare-covered Intensive Cardiac Rehabilitation Services	vices			
C Yes C No	Medicare-covered Pulmonary Rehabilitation Services				
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Medicare-covered Supervised Exercise Therapy (SET) Symptomatic Peripheral Artery Disease (PAD) Services	) for s			
	Additional Cardiac Rehabilitation Services				
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Additional Intensive Cardiac Rehabilitation Services				
C Every three years	Additional Pulmonary Rehabilitation Services				
C Every two years	Additional Supervised Exercise Therapy (SET) for Sym Peripheral Artery Disease (PAD) Services	ptomatic			
C Every year C Every six months C Every three months		Minimum Coinsurance	Maximum Coinsuranc	e	
C Other, Describe	Indicate Coinsurance percentage for Medicare-covered Cardiac Rehabilitation Services:				
You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.	Indicate Coinsurance percentage for Medicare-covered Intensive Cardiac Rehabilitation Services:				
Is there an enrollee Coinsurance?	Indicate Coinsurance percentage for Medicare-covered Pulmonary Rehabilitation Services:				
C Yes C No	Indicate Coinsurance percentage for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:				
	Indicate Coinsurance percentage for Additional Cardiac Rehabilitation Services:				
	Indicate Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services:				
	Indicate Coinsurance percentage for Additional Pulmonary Rehabilitation Services:				
	Indicate Coinsurance percentage for Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:				

PBP Data Entry System - Section B-3, Contract X0001, Plan 001, S File Help	Segment 000		- 0	×
Previous Next (Validate) Go	To: #3 Cardiac and Pulmonary Rehabilitation Services - B	ase 3	<b>-</b>	
Is there an enrollee Deductible?  Yes No Indicate Deductible Amount:  Yes No Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply): Medicare-covered Cardiac Rehabilitation Services Medicare-covered Intensive Cardiac Rehabilitation Services Medicare-covered Pulmonary Rehabilitation Services Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services Additional Pulmonary Rehabilitation Services Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	Indicate Copayment amount for Medicare-covered Cardiac Rehabilitation Services: Indicate Copayment amount for Medicare-covered Intensive Cardiac Rehabilitation Services: Indicate Copayment amount for Medicare-covered Pulmonary Rehabilitation Services: Indicate Copayment amount for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: Indicate Copayment amount for Additional Cardiac Rehabilitation Services: Indicate Copayment amount for Additional Intensive Cardiac Rehabilitation Services: Indicate Copayment amount for Additional Pulmonary Rehabilitation Services: Indicate Copayment amount for Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	Minimum Copayment	Maximum Copayment	

	ry System - S	ection B-3, Cont	ract X0001, Plan	001, Segme	nt 000	- 0	×
File Help Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#3 Cardiac and Pulmonary Rehabilitation Services - Base 4		
Is authorization	required?						
C Yes C No							
	iired for Cardi	iac and Pulmonar	y Rehabilitation	Services?			
C Yes C No							
		bilitation Services					
category. Do no Notes:	t repeat inform	nation captured in	n data entry.	IIS SELVICE			
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## #4a Emergency Services – Base 1

🖷 PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000						
File Help						
Previous Next (Validate) Exit (No Validate) Go To: #4a Emergency Services - Base 1						
Previous Next Exit   Previous Next     CLICK FOR DESCRIPTION OF BENEFIT     CLICK FOR DESCRIPTION OF BENEFIT     Calcade Benefits are not applicable for this Service     Category.        Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?        Calcade Maximum Enrollee Out-of-Pocket Cost            Indicate Maximum Enrollee Out-of-Pocket Cost amount:						
Enter number of Days or Hours:						

# #4a Emergency /Post-Stabilization Services – Base 2

File Help     Previous     Next     Exit (No     Ves     No     Indicate Maximum Copayment amount for Medicare-covered Benefits:     Indicate Maximum Copayment amount for Medicare-covered Benefits:     Indicate Maximum Copayment amount for Medicare-covered Benefits waived if admitted to hospital?     Yes     Note:     Indicate Maximum Copayment amount for Medicare-covered Benefits waived if admitted to hospital?     Select either Days or Hours within which admission must occur for waive::     Image:     Image: </th
Previous Exit (No Validate)     Is there an enrollee Copayment?     Yes     No     Indicate Minimum Copayment amount for Medicare-covered Benefits:     Indicate Maximum Copayment amount for Medicare-covered Benefits:     Indicate Maximum Copayment amount for Medicare-covered Benefits:     Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?     Select either Days or Hours within which admission must occur for waiver:     Days   Days     Hours     Exit (No     Authorization is not applicable for this Service Category.   Referral is not applicable for this Service Category.   Referral is not applicable for this Service Category.   Benefits:   Image: Comparison of the medicare-covered Benefits waived if admitted to hospital?     Select either Days or Hours within which admission must occur     Days     Hours
Yes   No   Indicate Minimum Copayment amount for Medicare-covered Benefits:   Indicate Maximum Copayment amount for Medicare-covered Benefits:   Indicate Maximum Copayment amount for Medicare-covered Benefits:   Indicate Maximum Copayment for Medicare-covered Benefits waived if admitted to hospital?   Select either Days or Hours within which admission must occur for waiver:   Days   Days   Hours   Referral is not applicable for this Service Category. Emergency Services Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:
Does the Emergency Services cost sharing count towards any plan- level deductible?  C Yes C No Vec

h

# #4b Urgently Needed Services – Base 1

File       Help         Previous       Next       Validate)         Go To:       #db Urgently Needed Services - Base 1             CLICK FOR DESCRIPTION OF BENEFIT             Enhanced Benefits are not applicable for this Service Category.         Maximum Plan Benefit Coverage is not applicable for this Service Category.         Is the cansurance for Medicare-covered Benefits         Previous       Select Maximum Enrollee Out-of-Pocket Cost amount:         Vers       Select Maximum Enrollee Out-of-Pocket Cost type:         No       Select the Maximum Enrollee Out-of-Pocket Cost type:         Pran-specified amount per period       Service Category 4a         Plan-specified amount per period       Covered Under Emergency Service Category 4a         Plan-specified amount per period       Cots for Medicare-covered Under Emergency Service Category 4a         Plan-specified amount per period       Indicate Maximum Coinsurance percentage to Medicare-covered Benefits:         Indicate Maximum Coinsurance percentage to Medicare-covered Benefits:       Indicate Maximum Coinsurance percentage to Medicare-covered Benefits:	🖷 PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000	-	$\times$
Previous       Next       Exit to Validate)         CLICK FOR DESCRIPTION OF BENEFIT       Indicate Maximum Enrollee Out-of-Pocket Cost amount:       Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital?         Enhanced Benefits are not applicable for this Service Category.       Indicate Maximum Enrollee Out-of-Pocket Cost amount:       Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital?         Is there a service-specific Maximum Enrollee Out-of-Pocket Cost       Select Maximum Enrollee Out-of-Pocket Cost       Select Admitted to hospital?         Is there a service-specific Maximum Enrollee Out-of-Pocket Cost       Select Maximum Enrollee Out-of-Pocket Cost       Select Waite amount:       Image: Select Waite amount of the poscific Maximum Enrollee Out-of-Pocket Cost type:       Select the Maximum Enrollee Out-of-Pocket Cost type:       Select Sharing cannot be greater than the amount established by CMS for Medicare-covered Urgently Needed Services.       Inter a merollee Coinsurance?       Yes       Indicate Minimum Coinsurance percentage         Indicate Minimum Coinsurance percentage       Indicate Minimum Coinsurance percentage       Indicate Maximum Coinsurance percentage       Indicate Maximum Coinsurance percentage	File Help		
CLCR FOR DESCRIPTION OF BENEFIT       Pocket Cost amount:       Benefits waived if admitted to hospital?         Enhanced Benefits are not applicable for this Service Category.       Select Maximum Enrollee Out-of-Pocket Cost?       Select Maximum Enrollee Out-of-Pocket Cost?       Select Maximum Enrollee Out-of-Pocket Cost?       Select Way sers       Select either Days or Hours within which admission must occur for waiver:         Yes       Every three years       Every sery year       Days       Hours         Select the Maximum Enrollee Out-of-Pocket Cost type:       Cost sering cannot be greater than the amount established by CMS for Medicare-covered Urgently Needed Services.       Enter number of Days or Hours:       Enter number of Days or Hours:         Yes       No       Select Mining cannot be greater than the amount established by CMS for Medicare-covered Urgently Needed Services.       Is there an enrollee Coinsurance?       Yes         No       Is there an enrollee Coinsurance percentage for Medicare-covered Benefits:       Indicate Minimum Coinsurance percentage       Indicate Minimum Coinsurance percentage	Exit Exit (No	<b>•</b>	
Indicate the maximum per visit amount:	CLICK FOR DESCRIPTION OF BENEFIT       Pocket Cost amount:       Bet         Enhanced Benefits are not applicable for this Service Category.       Select Maximum Enrollee Out-of-Pocket Cost?       Select Maximum Enrollee Out-of-Pocket Cost?       C         Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?       C Every three years       Select the Maximum Enrollee Out-of-Pocket Cost?       Select the Maximum Enrollee Out-of-Pocket Cost type:       Cost sharing cannot be greater than the amount established by CMS for Medicare-covered Urgently Needed Services.         Is there an enrollee Coinsurance?       Yes       No         Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:       Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	nefits waived if admitted to hospital? Yes No Select either Days or Hours within which Idmission must occur for waiver: Days Hours	

# #4b Urgently Needed Services – Base 2

🖷 PBP Data Entry System - Section B-4, Contract X( File Help	J001, Plan 001, Segment 000	- 0
Previous Next (Validate) Va	Go To: #4b Urgently Needed Services - Base 2 kit (No lidate)	<b>-</b>
Is there an enrollee Copayment?   Yes No Indicate Minimum Copayment amount for Medicare -covered Benefits:  Indicate Maximum Copayment amount for Medicare -covered Benefits:  Does the Urgently Needed Services cost sharing counttowards any plan-level deductible?  Yes No	Is the Copayment for Medicare-covered Benefits waived if and the dospital?	

# #4b Urgently Needed Services – Base 3

📲 PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000	_		$\times$
ïle Help		4	
Previous Next (Validate) Validate) Go To: #4b Urgently Needed Services - Base 3	<b>•</b>	]	
Authorization is not applicable for this Service Category.			
Referral is not applicable for this Service Category.			
Urgently Needed Services Notes			
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.			
Notes:			
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# #4c Worldwide Emergency/Urgent Coverage – Base 1

Previous Next (Validate) Validate)	Go To: #4c Worldwide Emergency/Urgent Coverage	- Base 1 💌
CLICK FOR DESCRIPTION OF BENEFIT  Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?  Yes No Select enhanced benefit Worldwide Emergency Coverage Worldwide Emergency Coverage Worldwide Emergency Transportation Select type of benefit for Worldwide Emergency Coverage: Mandatory Optional Select type of benefit for Worldwide Urgent Coverage: Mandatory Optional Select type of benefit for Worldwide Emergency Coverage Optional Select type of benefit for Worldwide Emergency Optional Select type of benefit for Worldwide Emergency Optional Select type of benefit for Worldwide Emergency Coptional Select type of benefit for Worldwide Emergency Optional Select	Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every two years Every year Every six months Every three months Other, Describe

# #4c Worldwide Emergency/Urgent Coverage – Base 2

👑 PBP Data En File Help	try System - S	section B-4, Contr	ract X0001, Plan	001, Segment 000	-	×
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #4c Worldwide Emergency/Urgent Coverage - Base 2		
Is there an enro		2		Is there an enrollee Copayment? Is there an enrollee D	advatible?	
O Yes	liee Comsula	ince:		O Yes     O Yes	eductible?	
C No				O No O No		
Select which V all that apply) Worldwide Worldwide	: Emergency C Urgent Cove	rage	isurance (Select	Select which Worldwide Services have a Copayment (Select all Indicate Deduct that apply):  Worldwide Emergency Coverage Worldwide Emergency Transportation	ble Amount:	
	mum Coinsura	Incepercentage fo	rWorldwide	Indicate Minimum Copayment amount for Worldwide Emergency Coverage:		
Indicate Maxi Emergency C		ance percentage fo	or Worldwide	Indicate Maximum Copayment amount for Worldwide Emergency Coverage:		
	oinsurance wa le if admitted t	aived for Worldwid o hospital?	le Emergency	Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?		
C Yes C No				C Yes C No		
Indicate Mini Urgent Cove		ance percentage fo	rWorldwide	Indicate Minimum Copayment amount for Worldwide Urgent Coverage:		
Indicate Maxi Urgent Cove		ance percentage fo	or Worldwide	Indicate Maximum Copayment amount for Worldwide Urgent Coverage:		
	pinsurance wa je if admitted t	aived for Worldwid o hospital?	le Urgent	Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?		
C Yes C No				C Yes C No		
	mum Coinsura ransportation	ance percentage fo :	r Worldwide	Indicate Minimum Copayment amount for Worldwide Emergency Transportation:		
	mum Coinsur ransportation	ance percentage fo :	or Worldwide	Indicate Maximum Copayment amount for Worldwide Emergency Transportation:		
		aived for Worldwid tted to hospital?	le Emergency	Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?		
C Yes C No				C Yes C No		

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# #4c Worldwide Emergency/Urgent Coverage – Base 3

🖳 PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000	_		$\times$
File Help			
Previous Next (Validate) Exit (No Validate) Go To: #4c Worldwide Emergency/Urgent Coverage - Base 3		•	
Authorization is not applicable for this Service Category. Referral is not applicable for this Service Category. Worldwide Emergency/Urgent Coverage Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:	^		
	v		

#### #5 Partial Hospitalization – Base 1

魓 PBP Data Entry System - Section B-5, Contract X0001, Plan 001, Segmen	nt 000 — 🗆 🗙
File Help	
Previous Next (Validate) Go To:	#5 Partial Hospitalization - Base 1
CLICK FOR DESCRIPTION OF BENEFIT  Inhanced Benefits are not applicable for this Service Category.  Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  Yes No  Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Select Maximum Enrollee Out-of-Pocket Cost periodicity:  Select Maximum Enrollee Out-of-Pocket Cost periodicity:  Every three years Every two years Every six months Other, Describe	Is there an enrollee Coinsurance?     Yes        Indicate Minimum Coinsurance percentage for Medicare-covered     Benefits:        Indicate Maximum Coinsurance percentage for Medicare-covered     Benefits:        Indicate Maximum Coinsurance percentage for Medicare-covered     Benefits:        Indicate Maximum Coinsurance percentage for Medicare-covered     Benefits:        Indicate Deductible     Indicate Deductible Amount:

#### #5 Partial Hospitalization – Base 2

🔡 PBP Data Entry System - Section B-5, Contract X0001, Plan 001, Sec	ment 000 — 🗆	×
File Help		
Go T	p: #5 Partial Hospitalization - Base 2	
Previous Next (Validate) Validate)		_
Is there an enrollee Copayment?	Partial Hospitalization Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
C No Indicate Minimum Copayment amount for Medicare-covered Benefits per day: Indicate Maximum Copayment amount for Medicare-covered Benefits per day: Is authorization required? C Yes	Notes:	
No     Is a referral required for Partial Hospitalization?     C Yes     C No	↓	
		//

#### #6 Home Health Services – Base 1

😸 PBP Data Entry System - Section B-6, Contr File Help	act X0001, Plan 001, Segment 000	-		$\times$
Previous Next (Validate)	Go To: #6 Home Health Services - Ba Exit (No Validate)	ise 1	]	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category, except for MMPs. Maximum Plan Benefit Coverage is not applicable for this Service Category.	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes         No         Indicate Maximum Enrollee Out-of-Pocket Cost amount:         Select Maximum Enrollee Out-of-Pocket Cost periodicity:         Every three years         Every two years         Every tyree months         Other, Describe	Is there an enrollee Coinsurance?          Yes         No         Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:         Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:		

#### #6 Home Health Services – Base 2

PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000 File Help	-	×
Previous Next (Validate) Services - Base 2	•	
Previous       Next       Validate         Is there an enrollee Deductible?		

#### #6 Home Health Services – Base 3

PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000 Help						_			
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#6 Home Health Services - Ba	ase 3		•	
authorizatior	n required?								
O Yes O No									
a referral rec	uired for Hom	e Health Services	?						
O Yes O No									
ome Health S	ervices Notes								
ote may inclu	de additional i	nformation to des mation captured in	cribe benefit in n data entry.	this service					
otes:									
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#### #6 Home Health Services – MMP – Base 1

🖳 PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segmer	nt 000	- 🗆 ×
File Help Previous Next (Validate) Co To:	#6 Home Health Services - MMP - Base 1	<b>_</b>
CLICK FOR DESCRIPTION OF BENEFIT     Does this plan provide Non-Medicare-covered Home Health Services?     Yes     No     Select Non-Medicare-covered Home Health Services:     Additional Hours of Care   Personal Care Services   Other 1   Other 2   Enter name of Other 1 Service:   Enter name of Other 2 Service:   Indicate Maximum Plan Benefit Coverage Amount?   Yes   No   Elect Maximum Plan Benefit Coverage amount:   Every three years   Every three years   Every three years   Every three months   Other, Describe	Is there a limit on the services provided?  Yes No Select Non-Medicare-covered Home Healt Additional Hours of Care Personal Care Services Other 1 Other 2 Indicate units a limit will be provided in for Additional Hours of Care: Sessions Visits Hours Points Neals Indicate numerical limit on the services provided for Additional Hours of Care: Select limit on services periodicity for Additional Hours of Care: Every day Every week Every month Every year Other, Describe	h Services where limit applies: Indicate units a limit will be provided in for Personal Care Services: Sessions Visits Hours Points Meals Indicate numerical limit on the services provided for Personal Care Services: Select limit on services periodicity for Personal Care Services: Every day Every week Every month Every year Other, Describe

#### #6 Home Health Services – MMP – Base 2

revious Next (Validate)	Go To: #6 Home Health S Exit (No Validate)	Services - MMP - Base 2	<b>_</b>	
Adicate units a limit will be provided in for ther 1: Sessions Visits Hours Points Meals Items/Other, Describe Idicate numerical limit on the services rovided for Other 1: Elect limit on services periodicity for ther 1: Every day Every week Every month Every year Other, Describe	Indicate units a limit will be provided in for Other 2: Sessions Visits Hours Points Meals Indicate numerical limit on the services provided for Other 2: Every day Every week Every week Every week Every week Every year Other, Describe	Is there an enrollee Coinsurance?  Yes No Select which Non-Medicare-covered Home Health Services have a Coinsurance (select all that apply): Additional Hours of Care Personal Care Services: Additional Hours of Care Personal Care Services Other 1: Other 2:		

#### #6 Home Health Services – MMP – Base 3

PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Se File Help	egment 000 — 🗆 🗙
Previous Next (Validate) Go	To: #6 Home Health Services - MMP - Base 3
Is there an enrollee Copayment?          Yes         No         Select which Non-Medicare-covered Home Health Services have a Copayment (select all that apply):         Additional Hours of Care         Personal Care Services         Other 1         Other 2         Indicate copayment         amount for one or more of the following services:         Orber 2         Other 1:         Other 2:         Other 2:         Does any service require qualification for and enrollment in a state-operated waiver program?         Yes         No         Select which service requires qualification for and enrollment in a state-operated waiver program:         Additional Hours of Care         Presonal Care Services         Other 2:	Is authorization required?   Yes   Yes   No   Home Health Services MMP Notes Notemay include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:

### #7a Primary Care Physician Services – Base 1

🖳 PBP Data Er	ntry System - S	ection B-7, Conti	ract X0001, Plan	001, Segn	nent 000	-		$\times$
File Help								
▲		Exit	Exit (No	Go To:	#7a Primary Care Physician Services - Base 1	-	l	
Previous	Next	(Validate)	Validate)					
Enhanced Ber Maximum Plan Service Categ Is there a serv O Yes O No Indicate Maxi	ice-specific Ma imum Enrollee ( ximum Enrollee ( ximum Enrollee ee years o years ar months ee months	OF BENEFIT oplicable for this S age is not applica ximum Enrollee O Dut-of-Pocket Cos e Out-of-Pocket C	ble for this		Is there an enrollee Coinsurance?   Yes No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits: Is there an enrollee Deductible? Yes No Indicate Deductible Amount: Is there an enrollee Copayment? Yes No Indicate Minimum Copayment amount per visit for Medicare-covered Benefits: Indicate Maximum Copayment amount per visit for Medicare-covered Benefits: Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:			

# #7a Primary Care Physician Services – Base 2

😸 PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000	_	$\times$
File Help		
Previous Next (Validate) Go To: #7a Primary Care Physician Services - Base 2	-	
Authorization is not applicable for this Service Category.		
Referral is not applicable for this service category.		
Primary Care Physician Services Notes		
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		
Notes:	_	
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# #7b Chiropractic Services – Base 1

PBP Data Entry System - Section B-7, Contract X000 Help Previous Next (Validate) Valid	Go To: #7b Chiropractic Services - Base 1	_
CLICK FOR DESCRIPTION OF BENEFIT	Enter Name of Other Service:	Is there a service-specific Maximum Plan Benefit Coverage amount?
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?  Ves No Select enhanced benefit: Routine Care Other Select type of benefit for Routine Care: C Mandatory O Optional Is this benefit unlimited for Routine Care?	Select type of benefit for Other Service: Mandatory Optional Is this benefit unlimited for Other Service? Yes No, indicate number Indicate number of visits for Other Service:	C Yes No Indicate Maximum Plan Benefit Coverage amount: Select Maximum Plan Benefit Coverage periodicity: C Every three years C Every three years C Every year C Every year C Every six months C Every three months C Other, Describe
Yes         No, indicate number         Indicate number of visits for Routine Care:         Select Routine Care periodicity:         Every three years         Every two years         Every year         Every six months         Every three months         Other, Describe	Select Other Service periodicity: C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	Is there a service-specific Maximum Enrollee Out-of- Pocket Cost?  Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amoun Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every three years Every three years Every year Every six months Every three months

#### #7b Chiropractic Services – Base 2

Help		
evious Next (Validate)	Go To: #7b Chiropractic Services - Base 2	<b>•</b>
	Is there an enrollee Copayment?  Yes No Select which Chiropractic Services have a Copayment (Select all that apply): Cherein Core Covered Chiropractic Services Covered Benefits: Chiropractic Services Covered Benefits: Chiropractic Services Chiropractic Service Service Service Service Service Service Service Service Service Servi	Is there an enrollee Deductible?   Yes  Is authorization required?  Yes No Is a referral required for Chiropractic Services?  Yes No

# #7b Chiropractic Services – Base 3

🖳 PBP Data Ent	try System - S	ection B-7, Contra	act X0001, Plar	n 001, Segme	ent 000		_	×
File Help								
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7b Chiropractic Services - Base 3		•	
		nformation to desc	ribe ben efit in t	his service c	category. Do not repeat information captured in data entry.			
Notes:						^		

# #7c Occupational Therapy Services – Base 1

revious Next (Validate)	Go To: #70 Occupational Therapy Exit (No Validate)	Services - Base 1	•	
CLICK FOR DESCRIPTION OF BENEFIT hanced Benefits are not applicable for this rvice Category, except for MMPs. eximum Plan Benefit Coverage is not plicable for this Service Category. there a service-specific Maximum Enrollee rt-of-Pocket Cost? 'Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Every three years Every year Every six months Cother, Describe  You must include total cost sharing to the beneficiary, including any facility cost sharing. Is there an enrollee Coinsurance?  Yes No  Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage per visit for Medicare-covered Benefits:	Is there an enrollee Deductible?  Yes Indicate Deductible Amount:  Sthere an enrollee Copayment?  Yes No Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:  Medicare-covered Benefits:		

# #7c Occupational Therapy Services – Base 2

🖶 PBP Data Ent ile Help	try System - S	Section B-7, Contr	act X0001, Plar	n 001, Segm	tent 000	-		$\times$
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7c Occupational Therapy Services - Base 2	•	]	
Is authorization	required?							
C Yes C No								
	uired for Occu	upational Therapy	Services?					
C Yes C No								
Occupational T	herapy Servic	ces Notes						
category. Do no		information to des mation captured in		his service				
Notes:						$\wedge$		
						~		

# #7c Occupational Therapy Services – MMP – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment File Help	000 — 🗆 ×
· · ·	C Occupational Therapy Services - MMP - Base 1
CLICK FOR DESCRIPTION OF BENEFIT   Description provide Non-Medicare-covered Occupational Therapy Service   Yes   No   Enter name of Non-Medicare-covered Occupational Therapy Service:   Inter name of Non-Medicare-covered Occupational Therapy Service   Yes   No   Indicate Maximum Plan Benefit Coverage amount:   Select Maximum Plan Benefit Coverage amount:   Select Maximum Plan Benefit Coverage amount:   Select Maximum Plan Benefit Coverage periodicity:   Very three years   Every two years   Every two months   Other, Describe	Is there an enrollee Coinsurance percentage:     Indicate Maximum Copayment amount:     Indicate Maximum Copayment amount:

## #7c Occupational Therapy Services – MMP – Base 2

🖶 PBP Data En ile Help	try System - S	Section B-7, Contr	ract X0001, Pla	n 001, Segm	ient 000	_		×
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7c Occupational Therapy Services - MMP - Base 2	•	]	
Is authorization	n required?							
C Yes C No								
ls a referral req	uired for Serv	ices?						
C Yes C No								
		ces MMP Notes						
category. Do no	de additional i ot repeat infor	information to des mation captured ir	cribe benefit in 1 n data entry.	this service				
Notes:						^		
						$\checkmark$		

### #7d Physician Specialist Services – Base 1

Rep Data Entry System - Section B-7, Contr File Help	act X0001, Plan 001, Segment 000		-	×
Previous Next (Validate)	Go To: #7d Physician Specialist S Exit (No Validate)	ervices - Base 1	•	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every year Every six months Every three months Other, Describe Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Is there an enrollee Deductible?		

### #7d Physician Specialist Services – Base 2

😾 PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000 File Help	-		×
Previous Next (Validate) Go To: #7d Physician Specialist Services - Base 2	<b>•</b>	]	
Is authorization required?			
C Yes C No			
Is a referral required for Physician Specialist Services?			
C Yes C No			
Physician Specialist Services Notes			
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:			
	^		
	~		
			/

# #7e Mental Health Specialty Services – Base 1

Republic PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000 File Help	- 🗆 ×
Previous Next (Validate) Validate) Go To: #7e Mental Health Speciality Services - Base '	1
Exit Exit (No	

# #7e Mental Health Specialty Services – Base 2

💀 PBP Data Er File Help	ntry System - S	Section B-7, Cont	ract X0001, Plan	n 001, Segn	nent 000	_	×
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7e Mental Health Speciality Services - Base 2	•	
Coinsurance Medicare Indicate Mi covered In Indicate Mi covered In Indicate Mi covered Gr Indicate Mi covered Gr No	Mental Health (Select all tha covered Indiv covered Grou nimum Coinsu dividual Session dividual Session nimum Coinsu oup Sessions: ximum Coinsu	I Specialty Service t apply): idual Sessions p Sessions rance percentage ons: rance percentage rance percentage irance percentage	for Medicare- for Medicare- for Medicare-		Is there an enrollee Copayment?          Yes         No         Select which Mental Health Specialty Services have a Copayment (Select all that apply):         Medicare-covered Individual Sessions         Indicate Covered Group Sessions         Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:         Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:         Indicate Maximum Copayment amount for Medicare-covered Group Sessions:         Indicate Maximum Copayment amount for Medicare-covered Group Sessions:         Indicate Maximum Copayment amount for Medicare-covered Group Sessions:		

## #7e Mental Health Specialty Services – Base 3

🚽 PBP Data En le Help	try System - S	ection B-7, Conti	ract X0001, Plar	n 001, Segm	ent 000	-	×
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7e Mental Heath Specialty Services - Base 3	•	
Is authorization	required?				_		
O Yes O No							
	uired for Ment	al Health Specialt	y Services - Nor	n-Physician	?		
O Yes O No							
Mental Health S							
ategory. Do no		nformation to des mation captured ir		this service			
otes:						^	
						$\sim$	

### #7f Podiatry Services – Base 1

BP Data Entry System - Section B-7, Contrac	ct X0001, Plan 001, Segment 000	– 🗆 ×
File Help Previous Next (Validate)	Go To: #7f Podiatry Services - Base 1 Exit (No Validate)	<b></b>
CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Podiatry Services as a supplemental benefit under Part C? Yes Routine Foot Care Select enhanced benefits: Routine Foot Care Select type of benefit for Routine Foot Care: Official Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits:	Select the Routine Foot Care periodicity:	<form></form>

### #7f Podiatry Services – Base 2

🖳 PBP Data En	try System -	Section B-7, Contr	act X0001, Plar	n 001, Segm	ent 000 — 🗆	) ×
File Help						
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7f Podiatry Services - Base 2	
Is there an enro	olleeCoinsur	ance?			Is there an enrollee Copayment?	1
C Yes C No					C Yes C No	
Select which Medicare- Routine Fo	covered Podi	ices have a Coinsu atry Services	rance (Selecta	il that apply)	): Select which Podiatry Services have a Copayment (Select all that apply):           Medicare-covered Podiatry Services           Routine Foot Care	
Indicate Minin	num Coinsura	ance percentage for	r Medicare-cov	ered Benefits	s: Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Maxin	mum Coinsur	ance percentage fo	r Medicare-cov	rered Benefit	ts: Indicate Maximum Copayment amount per visit for Medicare-covered Benefits	:
Indicate Minin	num Coinsura	ance percentage for	r Routine Foot	Care:	Indicate Minimum Copayment amount per visit for Routine Foot Care:	
Indicate Maxim	mum Coinsur	ance percentage fo	r Routine Foot	Care:	Indicate Maximum Copayment amount per visit for Routine Foot Care:	
Is there an enro	ollee Deducti	ble?				
Indicate De	ductible Amo	unt:				

## #7f Podiatry Services – Base 3

💀 PBP Data En File Help	try System - S	ection B-7, Contr	ract X0001, Plar	n 001, Segm	nent 000	-	$\times$
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7f Podiatry Services - Base 3	T	
Is authorization	required?						
C Yes C No							
ls a referral req	uired for Podi	atrist Services?					
C Yes C No							
Podiatry Servic							
category. Do no	de additional i ot repeat infor	nformation to des mation captured in	cribe benefit in t n data entry.	his service			
Notes:						^	
1						÷	

### #7g Other Health Care Professional – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000 —           File         Help							
Exit	Go To: #7g Other Health Care Profes Exit (No Validate)	ssional - Base 1 🗾					
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out- of-Pocket Cost? No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years Every year Every six months C Every three months O ther, Describe Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Is there an enrollee Deductible?					

## #7g Other Health Care Professional – Base 2

🚽 PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000 le 🛛 Help							×
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7g Other Health Care Professional - Base 2	T	
Is authorization	required?						
C Yes C No							
	uired for Othe	er Health Care Prof	essional Servio	ces?			
C Yes C No							
Other Health C							
category. Do no	de additional i ot repeat infor	information to dese mation captured in	cribe benefit in t 1 data entry.	his service			
lotes:						$\wedge$	
						~	

#### #7h Psychiatric Services – Base 1

💀 PBP File He		System - Se	ection B-7, Contra	ct X0001, Plan	001, Segm	ent 000 —	×
Previ	ous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7h Psychiatric Services - Base 1	
CLIC Enhan Maximu Is there O Ye: O No Indice Sele	ced Benefit um Plan Be e a service- s ate Maximu zvery three zvery two y zvery yaar zvery year zvery year	SCRIPTION s are not ap nefit Covera specific Max m Enrollee ( mum Enrollee years ears onths	(Validate) OF BENEFIT plicable for this Se ge is not applicab cimum Enrollee Ou Dut-of-Pocket Cost	rvice Category. le for this Servic t-of-Pocket Cos amount:	ce Category st?	х.	
	Every two y Every year	ears onths months					

#### #7h Psychiatric Services – Base 2

	try System - S	Section B-7, Cont	ract X0001, Plar	n 001, Segmen	t 000 —		×
File Help				-			
		Exit	Exit (No	Go To: 📔	7h Psychiatric Services - Base 2		
Previous	Next	(Validate)	Validate)	_		_	
Is there an enro	ollee Coinsura	ance?			is there an enrollee Copayment?		
C Yes					C Yes		
C No					C No		
Select which F		rvices have a Coir idual Sessions	nsurance (Selec	t all that apply)	: Select which Psychiatric Services have a Copayment (Select all that apply): Medicare-covered Individual Sessions		
Medicare-o	overed Group	p Sessions			Medicare-covered Group Sessions		
	linimum Coins Sessions:	surance percentag	e for Medicare-(	covered	Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:		
Indicate M Individual	laximum Coin: Sessions:	surance percenta	ge for Medicare-	covered	Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:		
Indicate M Group Set		surance percentag	e for Medicare-	covered	Indicate Minimum Copayment amount for Medicare-covered Group Sessions:		
Indicate M Group Se		surance percenta	ge for Medicare-	covered	Indicate Maximum Copayment amount for Medicare-covered Group Sessions:		
Is there an enro	ollee Deductik	nle?					
C Yes							
C No							
Indicate Dedu	ctible Amount	t					
I							

#### #7h Psychiatric Services – Base 3

	itry System - S	Section B-7, Contr	act X0001, Plar	n 001, Segm	ent 000	-		$\times$
File Help	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7h Psychiatric Services - Base 3	•		
Is authorizatio	n required?							
C Yes C No								
Is a referral rec	uired for Psyc	chiatric Services?						
C No								
Psychiatric Se Note may inclu category. Do n	deadditionali	information to desc mation captured in	cribe benefit in t data entry.	his service				
Notes:						^		
J								

### #7i PT and SP Services – Base 1

👷 PBP Data Entry System - Section B-7, Cont File Help	ract X0001, Plan 001, Segment 000	- 🗆 X
Previous Next (Validate)	Go To: #7i PT and SP Services - E Exit (No Validate)	ase 1
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category, except for MMPs. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? ○ Yes ○ No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every two years Every six months Every three months Other, Describe You must include total cost sharing to the beneficiary, including any facility cost sharing. Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage per visit for Medicare-covered Benefits:	Is there an enrollee Deductible?

### #7i PT and SP Services – Base 2

💀 PBP Data En	try System - S	Section B-7, Contr	act X0001, Pla	n 001, Segm	ent 000	-	×
File Help							
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7iPT and SP Services - Base 2	•	
Is authorization C Yes C No	n required?						
ls a referral req Services?	uired for Phys	ical Therapy and S	Speech-Langua	ige Patholog	у		
C Yes C No							
PT and SP Ser	vices Notes						
Note may inclu category. Do n	de additional i ot repeat infor	information to dese mation captured in	cribe benefit in t 1 data entry.	this service			
Notes:							
						^	
						$\vee$	

## #7i PT and ST – MMP – Base 1

	ntry System - S	Section B-7, Contra	act X0001, Plan	001, Segme	nt 000	_	×
File Help Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7i PT and ST - MMP - Base 1	•	
Does this plar Speech Thera C Yes No Select Non- Other 1 Other 2 Enter nam Enter nam Is there a serv Yes No Indicate Ma Select Maxi C Every th C Every th C Every s	Medicare-cove le of Other 1 Se rice-specific Ma rice-specific Ma mum Plan Bene rree years vo years ear ix months rree months	Medicare-covered	r Speech Thera it Coverage amo	py Services:	Is there an enrollee Coinsurance?		

#### #7i PT and ST – MMP – Base 2

😸 PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000 —						×
Previous Next	Exit (Validate)	Exit (No Validate)	о То: <mark>#7і Р</mark>	Fand ST - MMP - Base 2	•	
Is there an enrollee Copa          Yes         No         Select which Non-Med services have a Copay         Other 1         Other 2         Indicate copayment amount for one or more of the following services:         Other 1:         Other 2:	icare-covered Physica ment (select all that ap Minimum Maximu	im	erapy	Is authorization required?  Yes No Is a referral required for Services?  Yes No PT and SP Services MMP Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:		

### #7j Additional Telehealth Services – Base 1

PBP Data Entry System - Section B-7, Contract )	K0001, Plan 001, Segment 000	- 🗆 🗙
File Help		
	Go To: #7j Additional Telehealth Services - Base 1 Exit (No /alidate)	<b></b>
CLICK FOR DESCRIPTION OF BENEFIT Maximum Plan Benefit Coverage is not applicable for this Service Category. Do you offer an Additional Telehealth benefit for Part B services? Yes No	Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:         1a: Inpatient Hospital-Acute         1b: Inpatient Hospital-Paculta Services         2: Skilled Nursing Facility (SNF)         3-1: Cardiac Rehabilitation Services         3-2: Intensive Cardiac Rehabilitation Services         3-3: Pulmonary Rehabilitation Services         3-4: SET for PAD Services         4a: Emergency Services         4b: Urgently Needed Services         5: Partial Hospitalization         6: Home Health Services         7a: Primary Care Physician Services         7b: Chropractic Services         7c: Occupational Therapy Services         7d: Physician Specialist Services         7e: Group Sessions for Mental Health Specialty Services         7f: Podiatry Services         7g: Other Health Care Professional         7h1: Individual Sessions for Psychiatric Services         7h2: Group Sessions for Psychiatric Services         8a1: Diagnostic Radiological Services         8b2: Therapeutic Radiological Services         8b2: Therapeutic Radiological Services         8b2: Observation Services         9	Is there a service-specific Maximum Enrollee Out -of-Pocket Cost for Additional Telehealth? Yes         No         Indicate Maximum Enrollee Out-of-Pocket Cost amount:         Select the Maximum Enrollee Out-of-Pocket Cost periodicity:         Every year         Every six months         Other, Describe

## #7j Additional Telehealth Services – Base 2

Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7j Additional Telehealth Services - Base 2	
ls there an e	nrollee Coinst	urance?			Is there an enrollee Copayment?	
C Yes C No					C Yes C No	
Medica Indicate	e-covered Be	insurance percen			Indicate Minimum Copayment amount per visit for Medicare-covered Benefits: Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	
	nrollee Deduc	tible?				
C Yes C No						

### #7j Additional Telehealth Services – Base 3

PBP Data Entry System - Section B-7, Contract X00	1, Plan 001, Segment 000	- 🗆 ×
File Help Previous Next (Validate)	Go To: #7] Additional Telehealth Services - Base 3 (No ate)	<u> </u>
Previous       Next       Exit (Validate)       Exit Valid         Is authorization required for Additional Telehealth Services       O         O       Yes       O         Is a referral required for Additional Telehealth Services       O         Additional Telehealth Services Notes       Note may include additional information to describe ber category. Do not repeat information captured in data en Notes:	(No ate)	

## #7k Opioid Treatment Program Services – Base 1

👷 PBP Data Entry System - Section B-7, Contract ) File Help	(0001, Plan 001, Segment 000		-	$\times$
Previous Next (Validate)	Exit (No /alidate)	Services - Base 1	•	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out- of-Pocket Cost? Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Every three years Every year Every six months Every three months Other, Describe  Is there an enrollee Coinsurance?   Yes No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits: Indicate Maxi	Is there an enrollee Deductible?  Yes Indicate Deductible Amount:  Sthere an enrollee Copayment?  Yes No Indicate Minimum Copayment amount for Medicare-covered Benefits: Indicate Maximum Copayment amount for Medicare-covered Benefits:		

# #7k Opioid Treatment Program Services – Base 2

Help								
revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7k Opioid Treatment Program Services - Base 2		•	
authorizatio	n required?							
Yes No								
a referral rec	uired for Opio	id Treatment Prog	ram Services?					
Yes No								
	ent Program S	envices Notes						
ote may inclu	de additional i	nformation to des		nis service				
ote may inclu tegory. Do n	de additional i			nis service			T	
ote may inclu tegory. Do n	de additional i	nformation to des		nis service		^		
ote may inclu tegory. Do n	de additional i	nformation to des		nis service		^		
ote may inclu tegory. Do n	de additional i	nformation to des		nis service	•	^		
ote may inclu tegory. Do n	de additional i	nformation to des		nis service		^	-	
ote may inclu tegory. Do n	de additional i	nformation to des		nis service		^		
ote may inclu tegory. Do n	de additional i	nformation to des		nis service		^		
ote may inclu	de additional i	nformation to des		nis service		^		
ote may inclu tegory. Do n	de additional i	nformation to des		nis service		^		
ote may inclu tegory. Do n	de additional i	nformation to des		nis service		^		

PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 000						_	×
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#8a Outpatient Diag Procs/Tests/Lab Services - Base 1	<b>-</b>	
CLICK FOR	DESCRIPTION	OF BENEFIT					
		pplicable for this S age is not applical					
		aximum Enrollee O			ı.		
C Yes C No							
Indicate Maxi	mum Enrollee	Out-of-Pocket Cos	st amount:				
Select Maxin	num Eprollee (	Dut-of-Pocket Cost	periodicity:				
C Every th C Every tw	ree years 10 years		parroutoty.				
	x months ree months						
C Other, D	lescribe						

🔜 PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 000 File Help						-	×
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #8	a Outpatient Diag Procs/Tests/Lab Services - Base 2	•	
sharing. If you maximum fields may pay. Is there an enror Yes No Select which (Select all th Medicare Indicate I Diagnost	have a variety s to reflect the ollee Coinsura outpatient Di at apply): -covered Diag -covered Lab -covered Lab ic Procedures	ag Procs/Tests/La Inostic Procedure: Services surance percentag /Tests: Isurance percenta	lease utilize the st cost sharing t b Services have s/Tests ge for Medicare-	minimum and that a beneficiary e a Coinsurance	Services:		

🔛 PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 000						_	$\times$
File Help							
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#8a Outpatient Diag Procs/Tests/Lab Services - Base 3	•	
Is there an enro	ollee Deductib	ble?					
C Yes C No							
Indicate Deduc	ctible Amount	:					
Is there an enro	ollee Copaym	ent?					
C Yes C No							
Select which C Copayment (S		g Procs/Tests/Lab	Services have a	a			
	overed Diagn	ostic Procedures/T	Fests				
	num Copayme	nt amount for Medi	care-covered				
I Indicate Maxim Diagnostic Pro	num Copaymo ocedures/Test	ent amount for Med is:	icare-covered				
Indicate Minim Services:	um Copayme	nt amount for Medi	care-covered L	ab			
I Indicate Maxin Services:	num Copayme	ent amount for Med	icare-covered l	Lab			
		e services at the sa maximum copay a		n			
O Yes O No							

💀 PBP Data En File Help	ntry System - S	Section B-8, Contr	act X0001, Plar	n 001, Segme	ent 000	_	×
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#8a Outpatient Diag Procs/Tests/Lab Services - Base 4	T	
Is authorization	n required?						
C Yes C No							
ls a referral rec	quired for Outp	atient Diagnostic I	Procedures/Tes	st/Lab Service	es?		
C Yes C No							
C NO							
		/Lab Services Note					
Diagnostic Pro			cribe benefit in t	nis service c	ategory. Do not repeat information captured in data entry. Lab Services Notes:		
					^	^	
					<u>_</u>		
1					1		

# #8b Outpatient Diag/Therapeutic Rad Services – Base 1

🖳 PBP Data E	ntry System -	Section B-8, Cont	ract X0001, Plan	001, Segm	eent 000 —		$\times$
File Help							
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#8b Outpatient Diag/Therapeutic Rad Services - Base 1	•	
Enhanced Ber Maximum Plar Category. Is there a serv C Yes O No Indicate Maxi C Every th C Other, I You must inclu facility cost sh	nefits are not a nefits are not a ne Benefit Cover ice-specific Mi imum Enrollee mum Enrollee mum Enrollee mum Enrollee are years vo years ear ix months nee months nee months obescribe ide total cost si ide total cost si ide total cost si ide total cost si ide total cost si		ble for this Servi ut-of-Pocket Co st amount: t periodicity: iciary, including st sharing, pleas	st?	Select which Outpatient Diag/Therapeutic Rad Services have a Coinsurance (Select all that apply):         Medicare-covered Diagnostic Radiological Services         Medicare-covered X-Ray Services         Indicate Minimum Coinsurance percentage for Medicare-covered         Diagnostic Radiological Services (e.g., CT, MRI, etc):         Indicate Minimum Coinsurance percentage for other Medicare-covered         Diagnostic Radiological Services (e.g., CT, MRI, etc):         Indicate Minimum Coinsurance percentage for other Medicare-covered         Diagnostic Radiological Services (e.g., CT, MRI, etc):         Indicate Minimum Coinsurance percentage for other Medicare-covered         Therapeutic Radiological Services:         Indicate Minimum Coinsurance percentage for other Medicare-covered         Therapeutic Radiological Services:         Indicate Maximum Coinsurance percentage for other Medicare-covered         Therapeutic Radiological Services:         Indicate Maximum Coinsurance percentage for Medicare-covered X-Ray         Services:         Indicate Minimum Coinsurance percentage for Medicare-covered X-Ray         Services:         Indicate Maximum Coinsurance percentage for Medicare-covered X-Ray         Services:		

# #8b Outpatient Diag/Therapeutic Rad Services – Base 2

File Help Previous Next (Validate) Go To: #8b Outpatient Diag/Therapeutic Rad Services - Base 2
Exit Exit No
Is there an enrollee Deductible?
C Yes C No
Indicate Deductible Amount:
Is there an enrollee Copayment?
C Yes C No
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):
Medicare-covered Diagnostic Radiological Services Medicare-covered Therapeutic Radiological Services
☐ Medicare-covered X-Ray Services
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:
If a member receives multiple services at the same location on
the same day, does only the maximum copay apply?
C No

# #8b Outpatient Diag/Therapeutic Rad Services – Base 3

e Help							
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: 🏼 🛲	b Outpatient Diag/Therapeutic Rad Services - Base 3	•	
s authorization	n required?				Therapeutic Radiological Services Notes:		
O Yes						^	
O No							
a referral req Ray Services?	uired for Outpa ,	atient Diagnostic/	Therapeutic Ra	diological, and X			
) Yes							
O No							
		Rad Services Not information to des		this service			
ategory. Do n	ot repeat infor	mation captured in	n data entry.			$\sim$	
iagnostic Rad	diological Ser	vices (e.g., CT, MF	RI, etc.) Notes:		X-Ray Services Notes:		
				^		<u>^</u>	
				*		*	

### #9a Outpatient Hospital Services – Base 1

🛃 PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000 — 🛛					
File Help					
Previous Next (Validate) Go To: #9a Outpatient Hospital Services - Base 1	•				
Exit Exit No					
C Other, Describe					

#### #9a Outpatient Hospital Services – Base 2

💀 PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segm	nent 000	× 🗆 🗡
File Help		
Previous Next (Validate) Go To: Validate)	#9a Outpatient Hospital Services - Base 2	
Is there an enrollee Deductible?	Is there an enrollee Copayment?	Is authorization required for Medicare-covered Outpatient Hospital Services
C Yes C No	C Yes C No	C Yes C No
Select which Services have a Deductible (Select all that apply): Medicare-covered Outpatient Hospital Services Medicare-covered Observation Services	Select which Services have a Copayment (Select all that apply): Medicare-covered Outpatient Hospital Services Medicare-covered Observation Services	Is authorization required for Medicare-covered Observation Services? C Yes C No
Indicate Deductible Amount for Medicare-covered Outpatient Hospital Services:	Indicate Minimum Copayment amount per visit for Medicare- covered Outpatient Hospital Services:	Is a referral required for Medicare-covered Outpatient Hospital Services?
Indicate Deductible Amount for Medicare-covered Observation Services:	Indicate Maximum Copayment amount per visit for Medicare- covered Outpatient Hospital Services:	C Yes C No
	Indicate Minimum Copayment amount for Medicare-covered Observation Services:	Is a referral required for Medicare-covered Observation Services? C Yes C No
	Indicate Maximum Copayment amount for Medicare-covered Observation Services:	
	Copayment is charged: C Per day C Per stay C Other, Describe	

### #9a Outpatient Hospital Services – Base 3

💀 PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000					
File Help					
Previous Next (Validate) Services - Base 3	•				
Outpatient Hospital Services Notes					
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.					
	~				

# #9b ASC Services – Base 1

🔡 PBP Data Ent	try System - S	Section B-9, Cont	ract X0001, Plan	001, Segm	ent 000 —	[	$\times$
File Help							
•		Exit	Exit (No	Go To:	#9b ASC Services - Base 1	•	
Previous	Next	(Validate)	Validate)				
		1					
CLICK FOR E	DESCRIPTION	OF BENEFIT			You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize		
Enhanced Ben	efits are not a	pplicable for this S	Service Category.		the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.		
Maximum Plan	Benefit Cover	age is not applica	ble for this Servio	ce Category			
Is there a convis	o oposifio Ma	ximum Enrollee C	ut of Dookst Cor	+2	O Yes		
C Yes	ce-specific Ma	IXIMUM EnrolleeC	Jut-of-Pocket Cos	st?	Č No		
C No					Indicate Minimum Coinsurance percentage for Medicare-covered		
		ee Out-of-Pocket (			Benefits:		
C Covered u C Plan-spec		ent Hospital Servi per period	ces Category 9a				
		e Out-of-Pocket C	Cost amount:		Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:		
Select Maxi	imum Enrolle	e Out-of-Pocket C	ost periodicity:				
C Every t	hree years				]		
C Every t C Every y							
C Every s	six months						
C Every t C Other,	hree months Describe						

### #9b ASC Services – Base 2

😼 PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment File Help	- 000 -		×
	9b ASC Services - Base 2	]	
Is there an enrollee Deductible?    Yes   Indicate Deductible Amount:   Is there an enrollee Copayment?    Yes   No   Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:     Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	Is authorization required?		

### #9b ASC Services – Base 3

🖶 PBP Data En ile Help	try System - S	ection B-9, Conti	ract X0001, Plar	n 001, Segm	ent 000						-	×
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#9b AS	C Services -	Base 3				•	
ASC Services N	lotes											
Note may includ	de additional i	nformation to des	cribe benefit in t	his service (	ategory.	Do not repe	at informatio	n captured	in data entry.			
Notes:										 ^		
										~		

### #9c Outpatient Substance Abuse – Base 1

File Help  Previous Next Exit (Validate) Go To: ##COULdatient Substance Abuse - Base 1  CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category.  Maximum Plan Benefit Coverage is not applicable for this Service Category.  Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  Yes No Select the Maximum Enrollee Out-of-Pocket Cost type: Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost amount: Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: Covered under Outpatient Hospital Services Category 9a Covered under Outpatient Fortune Service Services Ser
Previous       Next       Exit (Wo Validate)         CLICK FOR DESCRIPTION OF BENEFIT
Enhanced Benefits are not applicable for this Service Category.  Maximum Plan Benefit Coverage is not applicable for this Service Category.  Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  Yes Yes No Select the Maximum Enrollee Out-of-Pocket Cost type: C Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every three years Every two years Every six months Every three months

### #9c Outpatient Substance Abuse – Base 2

💀 PBP Data Ent	try System - S	Section B-9, Cont	ract X0001, Plar	n 001, Segm	nent 000	_	×
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#9c Outpatient Substance Abuse - Base 2	•	
facility cost sha the minimum an sharing that a b Is there an enror Yes No Select which Coinsurance Medicare- Indicate Mini Individual Se Indicate Max Individual Se	ring, If you ha id maximum fi eveneficiary ma billee Coinsura Outpatient Su (Select all tha covered Indiv covered Grou mum Coinsur ssions: mum Coinsur ons: mum Coinsur	ance? ibstance Abuse se it apply): ridual Sessions	st sharing, pleas lowest and high rvices have a for Medicare-co for Medicare-co	vered	Is there an enrollee Deductible?   Yes No Indicate Deductible Amount:  Shere an enrollee Copayment?  Yes No Select which Outpatient Substance Abuse services have a Copayment (Select all that apply):  Medicare-covered Individual Sessions Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: Indicate Minimum Copayment amount for Medicare-covered Group Sessions: Indicate Maximum Copayment amount for Medicare-covered Group Sessions: Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: Indicate Maximum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Medicare-covered Group Sessions: Indicate Maximum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Medicare-covered Group Sessions: Indicate Maximum Copayment Amount fo		

### #9c Outpatient Substance Abuse – Base 3

	try System - S	Section B-9, Contr	act X0001, Pla	n 001, Segmei	nt 000	-	×
File Help Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#9c Outpatient Substance Abuse - Base 3	•	
Is authorization	required?						
C Yes C No							
	uired for Outp	atient Substance A	Abuse?		_		
C Yes C No							
Outpatient Sub Note may include		Notes information to desc	cribe benefit in t	his service			
category. Do no	ot repeat infor	mation captured in	data entry.				
Notes.						^	
						~	

# #9d Outpatient Blood Services – Base 1

🖳 PBP Data Er	ntry System - S	Section B-9, Contra	act X0001, Plar	1 001, Segm	ent 000	_	$\times$
File Help							
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#9d Outpatient Blood Services - Base 1	•	
If blood is give the blood shot Does the plan benefit under ○ Yes ○ No Select enhan □ Three (3) Select type i ○ Mandat ○ Optiona Maximum Plan Is there a serv ○ Yes ○ No	in as a part of a uld be included provide Outpe Part C? ced benefit: Pint Deductible of benefit for Ti pry I Benefit Cover ice-specific Ma	I OF BENEFIT	spital cost shar as a supplen tible Waived: le for this Serv rt-of-Pocket Co	ring.	Select Maximum Enrollee Out-of-Pocket Cost periodicity:                Every three years             Every two years             Every six months             Every six months             Every three months             Other, Describe          Is there an enrollee Coinsurance?                 Yes          Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits:          Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits:		

## #9d Outpatient Blood Services – Base 2

	itry System - S	Section B-9, Cont	ract X0001, Pla	n 001, Segm	ent 000 —		$\times$
File Help		_					
		Exit	Exit (No	Go To:	#9d Outpatient Blood Services - Base 2	-	
Previous	Next	(Validate)	Validate)				
Is there an enr	ollee Deductib	ble?			Outpatient Blood Services Notes		
C Yes					Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		
O No	ductible Amou	at			Notes:		
Indicate De	ductible Amou	nı.				$\sim$	
Is there an enr	ollee Copaym	ent?					
C Yes							
O No	imum Copeyr	nent amount per u	init for Medicara	covered			
Benefits:		nent amount per u	and for moundary				
 Indicate Ma	ximum Copayı	ment amount per u	unit for Medicar	e-covered			
Benefits:							
Is authorization	o required?						
© Yes	required?						
C No							
ls a referral rec	uired for Outp	atient Blood Serv	ices?				
C Yes C No							
						$\vee$	

### #10a Ambulance Services – Base 1

	ection B-10, Contra	act X0001, Plan	001, Segment 00	0	- 0
Help evious Next	Exit (Validate)	Exit (No Validate)	Go To: #10a /	Ambulance Services - Base 1	
CLICK FOR DESCRIPTION Inhanced Benefits are not ap aximum Plan Benefit Covera there a service-specific Mai Yes No Select which Services hav (Select all that apply): Medicare-covered Ground Ambul Select Maximum Enrolle Medicare-covered Air A O Every three years O Every six months O Other, Describe Indicate Maximum Enro Select the Maximum Enro Covered Air Ambulance Select the Maximum Enro Covered Air	pplicable for this Ser age is not applicable ximum Enrollee Out re a Maximum Enroll und Ambulance Services ollee Out-of-Pocket Co und Ambulance Services: ee Out-of-Pocket Co und Ambulance Services: s	e for this Service t-of-Pocket Cost lee Out-of-Pock vices Cost amount for ost periodicity fo vices:	t? et Cost Medicare- rr	Is there an enrollee Coinsurance?     Yes   No     Select which Services have a Coinsurance (Select all that apply):   Medicare-covered Ground Ambulance Services   Medicare-covered Air Ambulance Services   Indicate the Minimum Coinsurance percentage for Medicare-covered Ground Ambulance Services:   Indicate the Maximum Coinsurance percentage for Medicare-covered Air Ambulance Services:   Indicate Minimum Coinsurance percentage for Medicare-covered Air Ambulance Services:   Indicate Minimum Coinsurance percentage for Medicare-covered Air Ambulance Services:   Indicate Maximum Coinsurance percentage for Medicare-covered Air Ambulance Services:   Indicate Minimum Coinsurance percentage for Medicare-covered Air Ambulance Services:	Is this Coinsurance waived if admitted to hos

### #10a Ambulance Services – Base 2

Medicare-covered Ground Ambulance Services Medicare-covered Air Ambulance Services Indicate Deductible Amount for Medicare-covered Ground Ambulance Services: Ground Ambulance Services	Copayment (Select all that apply): J Ambulance Services pulance Services ayment amount for Medicare-covered
Yes       Yes         No       Select which Services have a Deductible (Select all that apply):         Medicare-covered Ground Ambulance Services       Select which Services have a (Covered Ground Ambulance Services)         Medicare-covered Air Ambulance Services       Medicare-covered Ground Ambulance Services)         Indicate Deductible Amount for Medicare-covered Ground Ambulance Services:       Indicate the Minimum Copa Ground Ambulance Services)	Copayment (Select all that apply): J Ambulance Services pulance Services ayment amount for Medicare-covered
No       C No         Select which Services have a Deductible (Select all that apply):       Select which Services have a (Medicare-covered Ground Ambulance Services)         Medicare-covered Air Ambulance Services       Medicare-covered Air Ambulance Air Ambulance Services         Indicate Deductible Amount for Medicare-covered Ground Ambulance Services:       Indicate the Minimum Copa Ground Ambulance Services	Copayment (Select all that apply): J Ambulance Services sulance Services ayment amount for Medicare-covered
Medicare-covered Ground Ambulance Services     Medicare-covered Ground Medicare-covered Air Ambulance Services      Indicate Deductible Amount for Medicare-covered Ground     Ambulance Services:     Ground Ambulance Services	I Ambulance Services pulance Services ayment amount for Medicare-covered
Ambulance Services: Ground Ambulance Service	ayment amount for Medicare-covered
	23.
Indicate Deductible Amount for Medicare-covered Air Ambulance Indicate the Maximum Copa Services: Ground Ambulance Service	ayment amount for Medicare-covered es:
Indicate Minimum Copayme Air Ambulance Services:	ient amount for Medicare-covered
Indicate Maximum Copaym Air Ambulance Services:	nent amount for Medicare-covered

### #10a Ambulance Services – Base 3

💀 PBP Data En File Help	try System - S	Section B-10, Cont	ract X0001, Pla	an 001, Segn	nent 000				-	×
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#10a Ambular	nce Services - Ba	ase 3		<b>_</b>	
Is authorization	n required for r	non-emergency Me	dicare services	?	_					
C No	applicable for	this Service Categ	ory.							
	deadditional	information to desc rmation captured in		his service						
Notes:								 	^	
									~	
										1,

### #10b Transportation Services – Base 1

e Help			
Previous Next (Validate) Valida			
CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Transportation Services as a upplemental benefit under Part C? Yes No Select enhanced benefit: Plan-approved Location Any Health-related Location Selecttype of benefit for Plan-approved Location: Mandatory Optional Is this benefit unlimited for number of trips for Plan -approved Location? Yes No	Select Type of Transportation for Plan-approved Location:  C One-way Round Trip Days Other, Describe Indicate number of days for Plan-approved Location: Select Mode of Transportation for Plan-approved Location: Select Mode of Transport	Indicate number of trips for Any Health-related Location: Select Any Health-related Location Trips periodicity: C Every three years Every two years Every year Every year Every six months Every three months Other, Describe Select Type of Transportation for Any Health- related Location: One-way Round Trip Days Other, Describe Indicate number of days for Any Health-	
Indicate number of trips for Plan-approved Location: Select Plan-approved Location Trips periodicity: Every three years Every two years Every year Every six months Every three months Other, Describe	Select type of benefit for Any Health-related Location: Optional Is this benefit unlimited for number of trips for Any Health-related Location? Yes No	related Location: Select Mode of Transportation for Any Health- related Location: Taxi Rideshare Services Bus/Subway Van Medical Transport Other, Describe	

### #10b Transportation Services – Base 2

revious Next	Exit (Validate)	Exit (No Validate)	s - Base 2
there a service-specific M overage amount? Yes No ndicate Maximum Plan Bene Every three years Every three years Every year Every six months Every hiree months Other, Describe	nefit Coverage amoun	Pocket Cost amount:	Is there an enrollee Coinsurance?

# #10b Transportation Services – Base 3

Go To: #10b Transportation Services - Base 3     Freevious Next     Next Vest     No     Indicate Minimum Copayment amount per trip:     Indicate Maximum Copayment amount per trip:     Indicate Maximum Copayment amount per trip:     Sa authorization required?     Yes     No     Sa areferral required for Transportation Services?     Yes     No     Sa areferral required for Transportation Services?     Yes     No	Texit       Exit       Exit       KNO         there an enrollee Copayment?       Transportation Services Notes         Yes       No         Indicate Minimum Copayment amount per trip:       Notes:         Indicate Maximum Copayment amount per trip:       Notes:         authorization required?       Yes         Yes       No         a referral required for Transportation Services?       Yes	Help										
Yes   No     Indicate Minimum Copayment amount per trip:   Indicate Maximum Copayment amount per trip:   authorization required?   Yes   No     a referral required for Transportation Services?     Yes	Yes       Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.         Indicate Minimum Copayment amount per trip:       Notes:         Indicate Maximum Copayment amount per trip:       Notes:         authorization required?       Yes         Yes       No         a referral required for Transportation Services?       Yes	revious	Next	Exit	Exit (No	Go To:	#10b Trans	portation Services	- Base 3	<b>•</b>		
authorization required? Yes No a referral required for Transportation Services? Yes	authorization required? ) Yes ) No a referral required for Transportation Services? ) Yes	) Yes ) No			rip:			Note may include category. Do not	additional informatio		^	
D Yes	) Yes	authorization		ment amount per t	trip:							
		) Yes	uired for Tran	sportation Service	85?						<	

# #11a DME – Base 1

PBP Data Entry System - Section B-11, Contract e Help				
Previous Next (Validate)	Go To: #11a DME - Base 1 Exit (No /alidate)		•	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category, except for MMPs. Maximum Plan Benefit Coverage is not applicable for this Service-specific Maximum Enrollee Out- of-Pocket Cost? Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Deductible?  C Yes No Indicate Deductible Amount: C Yes No Indicate Minimum Copayment amount per item for Medicare-covered Benefits: Indicate Maximum Copayment amount per item for Medicare-covered Benefits:		

# #11a DME – Base 2

		try System - S	Section B-11, Con	tract X0001, Pla	an 001, Segr	nent 000 —		×
Equipment (DME)?           Types         Is authorization required?         Types         No         Durable Medical Equipment Notes         Notemay include additional information to describe benefit in this service category. Do not repeat information captured in data entity:         Notes:	File Help Previous	Next	Exit	Exit (No	Go To:	#11a DME - Base 2	•	
Note:			manufacturers for	Durable Medica	il			
C Yes   Notes:	C Yes C No							
Not		n required?						
Durable Medical Equipment Notes Notemay include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:	C Yes C No							
Note: may include additional information to describe benefit in this service adaptory. Do not repeat information captured in data entry.	Referral is not	applicable for	this Service Categ	ory.				
	Durable Medic	al Equipment I	Notes					
					his service			
	Notes:							
						^		
						×		

### #11a DME – MMP – Base 1

🖳 PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment	t 000 —		נ	×
File Help				
Previous Next (Validate) Go To:	1a DME - MMP - Base 1	•		
Exit Exit (No	Is there an enrollee Coinsurance?			

### #11a DME – MMP – Base 2

骎 PBP Data Entry Syster File Help	n - Section B-11, Cont	ract X0001, Plan	n 001, Segment	- 000 -		×
Previous Next	Exit (Validate)	Exit (No Validate)	Go To: #1	1a DME - MMP - Base 2	]	
Is there an enrollee Copa Yes No Select which Non-Met Copayment (select all Durable Medical El Other 1 Other 2 Indicate copayment amount for one or more of the following services: Durable Medical Equipment for use outside the home: Other 1: Other 2:	dicare-covered Durable that apply): quipment for use outsic	le the home	nent(s) have a	Is authorization required?   Yes   Yes   Yes   No   Durable Medical Equipment MMP Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.   Notes:		

# #11b Prosthetics/Medical Supplies – Base 1

🙀 PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000 - File Help	-	×
Previous Next (Validate) Go To: #11b Prosthetics/Medical Supplies - Base 1	•	
CLICK FOR DESCRIPTION OF BENEFIT       Is there an enrollee Coinsurance?         Enhanced Benefits are not applicable for this Service Category, except for Mainum Plan Benefit Coverage is not applicable for this Service Category.       Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?         Yes       Imata apply:         C Yes       Medicate-covered Medical Supplies have a Coinsurance (Select all that apply:         C Yes       Medicate-covered Medical Supplies         Indicate Maximum Enrollee Out-of-Pocket Cost amount:       Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:         C Server three years       Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:         C Yery year       Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:         C Yery year       Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:         C Yery year       Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:         C Yery Year       Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:         C Yery Yue yea		

# #11b Prosthetics/Medical Supplies – Base 2

BP Data Entry System - Section B-11, Contract X0001, Plan 001, Seg	ment 000 — 🗆	×
File Help Previous Next (Validate) File Help Exit Sector Content Exit (No Validate) Go To:	#11b Prosthetics/Medical Supplies - Base 2	
Previous     Ivext     (validate)     validate)       Is there an enrollee Deductible?	Indicate Minimum Copayment amount per item for Medicare- covered Prosthetic Devices: Indicate Minimum Copayment amount per item for Medicare- covered Medical Supplies: Indicate Maximum Copayment amount per item for Medicare- covered Medical Supplies:	

# #11b Prosthetics/Medical Supplies – Base 3

PBP Data Ent e Help	try System - S	Section B-11, Con	tract X0001, Pl	an 001, Segr	nent 000	_		×
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#11b Prosthetics/Medical Supplies - Base 3	•	[	
s authorization	required?							
O Yes O No								
Referral is not a	pplicable for	this Service Categ	jory.					
Prosthetics/Me								
ategory. Do no	t repeat infor	information to des mation captured ir	n data entry.	this service				
Notes:						~		
						~		

# #11b Prosthetics/Medical Supplies – MMP – Base 1

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment File Help	- 000 -	×
· · · · · · · · · · · · · · · · · · ·	1b Prosthetics/Medical Supplies - MMP - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT         Does this plan provide Non-Medicare-covered Prosthetics/Medical Supplies?         Yes         No         Enter name of Non-Medicare-covered Service:         Indicate Aservice-specific Maximum Plan Benefit Coverage amount?         Yes         No         Indicate Maximum Plan Benefit Coverage amount:         Select Maximum Plan Benefit Coverage periodicity:         Every three years         Every three years         Every three onths         Other, Describe         Is there an enrollee Coinsurance?         Yes         No         Indicate Coinsurance Percentage:	Is there an enrollee Copayment?  Yes No Indicate Copayment Amount:  Yes No Is a referral required for Services?  Yes No Prosthetics/Medical Supplies MMP Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:	

### #11c Diabetic Supplies and Services – Base 1

	ntry System - S	Section B-11, Cont	ract X0001, Plar	n 001, Segm	ient 000	_	×
File Help Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#11c Diabetic Supplies and Services - Base 1	•	
Enhanced Be Maximum Plat Is there a serv C Yes No Select Maxim C Covered Plan-spu Indicate Max Select Max C Every C Every C Every C Every C Every C Every C Every C Every C Every	n Benefit Cover ice-specific Ma num Enrollee O under DME Ca wolfied amount p ximum Enrollee three years two years year year six months three months	oplicable for this Se age is not applicab aximum Enrollee Ou ut-of-Pocket Cost t tegory 11a ber period e Out-of-Pocket Cos Out-of-Pocket Cos	le for this Servic It-of-Pocket Cos ype: st amount:	ce Category	Select which Diabetic Supplies and Services have a Coinsurance (Select all that apply):         Medicare-covered Diabetic Supplies         Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Supplies:         Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Supplies:         Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Supplies:         Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:         Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:         Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:         Indicate Therapeutic Shoes or Inserts:         Indicate Deductible?         Yes         No         Indicate Deductible Amount:		

### #11c Diabetic Supplies and Services – Base 2

	em - Section B-11, Cont	ract X0001, Plan	001, Seg	ment 000	-	$\times$
File Help Previous Ne	Exit	Exit (No	Go To:	#11c Diabetic Supplies and Services - Base 2	•	
Frevious Ne	xt (Validate)	Validate)				
Is there an enrollee Co	payment?			Is authorization required?	1	
O Yes O No				O Yes O No		
(Select all that appl Medicare-covered Medicare-covered Indicate Minimum C covered Diabetes S	ed Diabetes Supplies ed Diabetic Therapeutic S copayment amount per ité upplies: Copayment amount per it	hoes or Inserts em for Medicare-		Referral is not applicable for this Service Category. Diabetic Supplies and Services Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:		
covered Diabetic Th Indicate Maximum ( covered Diabetic Th Do you limit Diabetic Si manufacturers?	opayment amount per its lerapeutic Shoes or Inser Copayment amount per it lerapeutic Shoes or Inser upplies and Services to th	ts: em for Medicare- ts:				
<sup>C</sup> №				ν		

# #12 Dialysis Services – Base 1

🔜 PBP Data Entry System - Section B-12, Con File Help	tract X0001, Plan 001, Segment 000		-	$\times$
Previous Next (Validate)	Go To: #12 Dialysis Services - Base Exit (No Validate)	1	•	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every two years Every year Every six months Other, Describe You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay. Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Is there an enrollee Deductible?  Yes No Indicate Deductible Amount:  Is there an enrollee Copayment?  Yes No Indicate Minimum Copayment amount per session for Medicare-covered Benefits: Indicate Maximum Copayment amount per session for Medicare-covered Benefits: Reminder: Dialysis received from an Out-of- Network provider will be covered at the In- Network cost.		

# #12 Dialysis Services – Base 2

Rep PBP Data Entry System - Section B-12, Contract X0001, Plan 001, Segment 000 File Help	-	×
Previous Next (Validate) Services - Base 2	•	
Previous     Next     (validate)       Is authorization required?	~	

### #13a Acupuncture – Base 1

🖷 PBP Data Entry System - Section B-13, Contract X0	0001, Plan 001, Segment 000	-	-	$\times$
File Help				
	Go To: #13a Acupuncture - Base t (No date)	1	•	
CLICK FOR DESCRIPTION OF BENEFIT				
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out- of-Pocket Cost?		
C Yes C No	C Yes C No	C Yes C No		
Select enhanced benefit:	Indicate Maximum Plan Benefit Coverage amount:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:		
Select type of benefit for Number of Treatments:	, Select Maximum Plan Benefit Coverage periodicity:	Select Maximum Enrollee Out-of-Pocket Cost periodicity:		
C Mandatory C Optional	C Every three years	C Every three years		
Is this benefit unlimited for Number of Treatments?	C Every two years C Every year C Every six months	C Every two years C Every year C Every six months		
C Yes C No	C Every three months C Other, Describe	C Every three months C Other, Describe		
Indicate limit for Number of Treatments:				
C Every three years Every two years Every year Every six months Every three months Other, Describe				

### #13a Acupuncture – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Pl File Help	in 001, Segment 000	- 🗆 ×
Previous Next (Validate)	Go To: #13a Acupuncture - Base 2	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
C Yes C No	C Yes C No	
Indicate Minimum Coinsurance percentage:	Indicate Minimum Copayment amount per treatment:	
Indicate Maximum Coinsurance percentage:	Indicate Maximum Copayment amount per treatment:	
Is there an enrollee Deductible?	Is authorization required?	
C Yes C No	C Yes C No	
Indicate Deductible Amount:	Is a referral required for Acupuncture?	
	C Yes C No	

## #13a Acupuncture – Base 3

	try System - S	Section B-13, Con	tract X0001, Pla	an 001, Segr	nent 000					<u>25</u>		$\times$
le Help											_	
•		Exit	Exit (No	Go To:	#13a Acup	uncture - Base	:3				•	
Previous	Next	(Validate)	Validate)									
Acupuncture N	otes											
Note may includ	de additional i	information to des	cribe benefit in t	his service c	ategory, Do	notrepeatinfo	ormation capt	ured in data entr	v.			
Notes:												
										~		
										4		

### #13b OTC Items – Base 1

💀 PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segr	ment 000 —		×
File Help			
Previous Next (Validate) Go To: Utalidate)	#13b OTC Items - Base 1		
CLICK FOR DESCRIPTION OF BENEFIT Medicare-Medicaid plans may not use this section to provide benefit information about any OTC items that are submitted under the integrated formulary. Information about those benefits will be entered in the Rx section of the PBP. This section should only be used to provide benefit information about OTC items that are covered as a supplemental benefit. Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C? Yes No Select type of benefit for OTC Items: Mandatory Optional	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Select Maximum Enrollee Out-of-Pocket Cost periodicity:  Every three years Every two years Every year Every six months Every three months Every month Every		
Is there a service-specific Maximum Plan Benefit Coverage amount?  Yes No Indicate Maximum Plan Benefit Coverage amount:	Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit? C Yes C No		
Select Maximum Plan Benefit Coverage periodicity: C Every three years E Every two years E Every year E Every six months E Every three months E Every month	Nicotine Replacement Therapy (NRT) Attestation: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.		
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused? C Yes C No			

# #13b OTC Items – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, e Help				
Previous Next (Validate) Go	To: #13b OTC Items - Base 2	•	]	
s there an enrollee Coinsurance?  Yes Indicate Minimum Coinsurance percentage: Indicate Maximum Coinsurance percentage: Sthere an enrollee Deductible? Yes No Indicate Deductible Amount:	Is there an enrollee Copayment?  Yes No Indicate Minimum Copayment amount: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Yes No Authorization is not applicable for this service category. Referral is not applicable for this service category.			

### #13b OTC Items – Base 3

PBP Data Ent e Help	try System - S	Section B-13, Cont	ract X0001, Pla	an 001, Segi	ment 000				_		>
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#13b OTC I	tems - Base 3			•	]	
OTC Items Note	es										
lote may includ	de additional i	nformation to desc	cribe ben efit in t	h <mark>is service</mark> c	category. Do	notrepeatinfo	rmation capture	ed in data entry.			
lotes:									 ^		
									~		

### #13c Meal Benefit – Base 1

BP Data Entry System - Section B-13, Contract X0001, Plan 001, Se Help	gment 000		-	٥	
revious Next (Validate) Go T	e: #13c Meal Beneft - Base 1	•			
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Plan Benefit Coverage amount	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?			
so the plan provide a minite or data of mean of the analysis of opplemental benefit under Part C? Note: Only primarily health- ated means offered in accordance with Chapter 4 of the MMCM build be entered in this section.	C Yes C No	C Yes C No			
Yes No	Indicate Maximum Plan Benefit Coverage amount:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:			
elect type of benefit for Meals:					
Mandatory Optional	Select Maximum Plan Benefit Coverage periodicity:	Select Maximum Enrollee Out-of-Pocket Cost periodicity:			
elect the type of primarily health related meals benefit fered: Immediately following surgery or inpatient hospitilization For a medical condition or potential medical condition	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe			
that requires the enrollee to remain at home for a period of time					

### #13c Meal Benefit – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, S File Help	Segment 000	<u></u>		Х
	o: #13c Meal Benefit - Base 2	•	·	
Is there an enrollee Coinsurance?  Yes Indicate Minimum Coinsurance percentage: Indicate Maximum Coinsurance percentage: Is there an enrollee Deductible?  Yes No Indicate Deductible Amount: Indicate Deductible Amount:	Is there an enrollee Copayment?  Yes Indicate Minimum Copayment amount: Indicate Maximum Copayment amount: Is authorization required?  Yes No Is a referral required for the Meal Benefit?  Yes No			

# #13c Meal Benefit – Base 3

Help	uy system - S	ection B-13, Cont	ιατι λυυυτ, Ρί	in our, segn	IENT UUU						)
revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	#13c Meal Be	enefit - Base 3				•	
eal Benefit No	otes										
ote may inclu	de additional i	nformation to des	cribe benefit in f	his service ca	ategory. Do n	otrepeatinform	nation capture	ed in data entry.			
otes:									 <u>^</u>		
									~		

#### #13d Other 1 – Base 1

PBP Data Entry System - Section B-13, Con	tract X0001, Plan 001, Segment 000	_ 8
🖌 📐 🖌 🦉 Go 1	Fo: #13d Other 1 - Base 1	
Exit Exit No revious Next (Validate) Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Indicate Maximum Plan Benefit Coverage amount:	
ote: After completing your data entry in this category, if you delete		
L text in the 'Entername of Service (Optional):' field you will lose previously entered data.	Select Maximum Plan Benefit Coverage periodicity:	
ou may edit the name of the service text partially without losing all eviously entered data.	C Every three years C Every two years	
o not put Medicare-covered benefits in this service category (e.g.,	C Every year C Every six months	
o not include home health, nutritional support, transportation, edical devices etc).	C Every three months	
ver-the-Counter (e.g., adult diapers, band-aids, etc) benefits ould only be entered in B-138.	C Other, Describe	
providing a supplemental benefit, enter a descriptive title. "Other"	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
not an acceptable title.	O Yes	
nter name of Service (Optional):	C No	
	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
elect type of benefit for Other 1:	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
Mandatory Optional	C Every three years C Every two years	
opional	O Every year	
there a service-specific Maximum Plan Benefit Coverage amount?	C Every six months	
Yes	C Every three months	
No	C Other, Describe	

# #13d Other 1 – Base 2

💀 PBP Data Entry System - See File Help	ction B-13, Contract X0001, Pla	n 001, Segment 000	- 🗆 ×
Previous Next	Exit Exit (No (Validate) Validate)	Go To: #13d Other 1 - Base 2	<b>_</b>
Is there an enrollee Coinsuran	ce? nce percentage: nce percentage: ?	Is there an enrollee Copayment?	

# #13d Other 1 – Base 3

	try System - S	ection B-13, Cont	tract X0001, Pla	an 001, Segr	ment 000					<u>-</u>		X
File Help Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#13d Othe	er 1 - Base 3					•	
Other 1 Notes												
	de additional i	nformation to des	cribe ben efit in ti	his service o	ategory. D	o notrepeatin	formation cap	ptured in data er	ntry.			
Notes:										^		
										~		

#### #13e Other 2 – Base 1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, S File Help	egment 000	<u>11</u>		×
Previous Next (Validate) Go T	o: #13e Other 2 - Base 1	•	·	
CLICK FOR DESCRIPTION OF BENEFIT Note: After completing your data entry in this category, if you delete ALL text in the 'Enter name of Service (Optional).' field you will lose all previously entered data. You may edit the name of the service text partially without losing all previously entered data. Do not put Medicare-covered benefits in this service category (e.g., do not include home health, nutritional support, transportation, medical devices etc). Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13B. If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.	Indicate Maximum Plan Benefit Coverage amount: Select Maximum Plan Benefit Coverage periodicity: Select Maximum Enrollee Out-of-Pocket Cost? Select Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pock			
Select type of benefit for Other 2: C Mandatory C Optional Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes C No	Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years E Every year E Every year E Every six months E Every three months Other, Describe			

# #13e Other 2 – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, File Help	Segment 000	- 0	×
Previous Next (Validate) Go	To: #13e Other 2 - Base 2	<b>•</b>	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?  Yes Indicate Minimum Copayment amount: Indicate Maximum Copayment amount: Is authorization required? Yes No Is a referral required for Other Services? Yes No		

# #13e Other 2 – Base 3

Help									 	-	
revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	#13e Other	2 - Base 3				·]	
ther 2 Notes											
	de additional i	nformation to des	cribe benefit in t	his service	category, Do	notrepeatinform	nation captured	in data entry.			
ites:									^		
									$\vee$		

# #13f Other 3 – Base 1

💀 PBP Data Entry System - Section B-13, Contract X0001, Plan 001, S	Segment 000	<u>10</u>	×
File Help			
Go 1	To: #13f Other 3 - Base 1		
Previous Next (Validate) Validate)			
CLICK FOR DESCRIPTION OF BENEFIT	Indicate Maximum Plan Benefit Coverage amount:		
Note: After completing your data entry in this category, if you delete ALL text in the 'Enter name of Service (Optional):' field you will lose	Select Maximum Plan Benefit Coverage periodicity:		
all previously entered data.	<ul> <li>○ Every three years</li> <li>○ Every two years</li> </ul>		
You may edit the name of the service text partially without losing all previously entered data.	C Every two years		
previously entered data.	C Every six months		
Do not put Medicare-covered benefits in this service category (e.g., do not include home health, nutritional support, transportation,	C Every three months		
medical devices etc).	C Other, Describe		
Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13B.	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
If providing a supplemental benefit, enter a descriptive title. "Other"	C Yes		
is not an acceptable title.	C No		
Enter name of Service (Optional):	Indicate Maximum Enrollee Out-of-Pocket Cost amount:		
	Select Maximum Enrollee Out-of-Pocket Cost periodicity:		
Select type of benefit for Other 3:	C Every three years		
C Mandatory	C Every two years		
C Optional	C Every year C Every six months		
Is there a service-specific Maximum Plan Benefit Coverage amount?	C Every three months		
C Yes	C Other, Describe		
C No			
			1

# #13f Other 3 – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Ie Help	Segment 000	- D >
	To: #13f Other 3 - Base 2	<b>•</b>
Is there an enrollee Coinsurance?  Yes Indicate Minimum Coinsurance percentage: Indicate Maximum Coinsurance percentage: Is there an enrollee Deductible? Yes No Indicate Deductible Amount:	Is there an enrollee Copayment?  Yes No Indicate Minimum Copayment amount: Indicate Maximum Copayment amount: Is authorization required? Yes No Is a referral required for Other Services? Yes No	

# #13f Other 3 – Base 3

PBP Data Entr	ry System - S	ection B-13, Cont	ract X0001, Pla	n 001, Segm	nent 000				<u></u>		)
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#13f Other 3	- Base 3			<u>.</u>	-	
Other 3 Notes											
	le additional ii	nformation to desc	cribe benefit in ti	his service ca	ategory. Do n	otrepeatinfor	mation captur	ed in data entry.			
lotes:									 ^		
									~		

# #13g Dual Eligible SNPs with Highly Integrated Services – Base 1

🛃 PBP Data Er	ntry System - S	Section B-13, Con	tract X0001, Pla	an 001, Segment 000		-	$\times$
File Help Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #13g Dua	al Eligible SNPs with Highly Integrated Services - Base 1	•	
Plans only fill they qualify fo with Highly Int Dual Eligible S I attest that plan qualifi SNPs with additional PBP do not eligible to i or through You may edit th entered data. If providing a : acceptable title Enter name	The new supp egrated Service NPs with High I have receive es for the new Highly Integra supplemental I inappropriate eccive under the local jurisd ne name of the supplemental B supplemental B supplemental B supplemental B supplemental B supplemental B	hif they have recei lemental benefit fl less. Inly Integrated Services d written notificati supplemental ben ted Services for C benefit(s) that the 3 g vaiver, the State inction in which the service text partia benefit, enter a des	exibility for certa vices Benefit Att on from CMS th left flexibility for Y 2022. I further SNP describes Sing services Medicaid plan, ey reside. Illy without losin scriptive title. "Of	at this individual SNP certain Dual Eligible attest that the n this section of the that enrollees are Medicare Part A or B, g all previously ther" is not an			

#13g Dual Eligible SNPs with Highly Integrated Services – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, So ile Help	egment 000		$\times$
	o: #13g Dual Eligible SNPs with Highly Integrated Services - Base 2	•	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?  Yes Indicate Minimum Copayment amount: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Is authorization required? Yes No Is a referral required for Other Services? No		

# #13g Dual Eligible SNPs with Highly Integrated Services – Base 3

🚽 PBP Data E	ntry System - S	Section B-13, Cont	tract X0001, Pla	in 001, Seg	ment 000					<u>87</u>		>
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#13g Dual E	ligible SNPs wi	ith Highly Integr	ated Services - B	ase 3		•	
Dual Eligible S	SNPs with High	nly Integrated Servi	ces Notes									
Note may incl	ludeadditional	information to des	cribe benefit in t	his service	category. Do	notrepeatinfo	ormation captu	red in data entry.				
Notes:										<u> </u>		
										~		
										~		

revious Next (Validate) Go To: #13h Ad	Itional Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Enter name of Other 1 Service:	
bes the plan provide Additional Services? Yes No	Enter name of Other 2 Service:	
Select Additional Services (select all that apply): Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services A Tobacco Cessation Counseling for Pregnant Women	Enter name of Other 3 Service:	
Freestanding Birth Center Services Respiratory Care Services Family Planning Services Nursing Home Services	Enter name of Other 4 Service:	
Home and Community Based Services Personal Care Services Self-Directed Personal Assistance Services Private Duty Nursing Services	Enter name of Other 5 Service:	
Case Management (Long Term Care) Institution for Mental Disease Services for Individuals 65 or Older Services in an Intermediate Care Facility for Individuals with Intellectual Disabilitie Case Management	Enter name of Other 6 Service:	
Other 1 Other 2 Other 3	Enter name of Other 7 Service:	
Other 4 Other 5 Other 6 Other 7	Enter name of Other 8 Service:	
Other 8 Other 9 Other 10 Other 11	Enter name of Other 9 Service:	
Other 12 Other 13 Other 14	Enter name of Other 10 Service:	
Other 15 Other 16 Other 17 Other 18	Enter name of Other 11 Service:	
Other 19 Other 20 Other 21	Enter name of Other 12 Service:	
Other 22 Other 23	Enter name of Other 13 Service:	

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segn File Help	ment 000	<u></u>	×
Previous Next (Validate) Go To:	#13h Additional Services - Base 2	•	
Enter name of Other 14 Service:	Enter name of Other 27 Service:	1	
Enter name of Other 15 Service:	Enter name of Other 28 Service:	) 1	
Enter name of Other 16 Service:	Enter name of Other 29 Service:	1	
Enter name of Other 17 Service:	Enter name of Other 30 Service:	1	
Enter name of Other 18 Service:	Enter name of Other 31 Service:	1	
Enter name of Other 19 Service:	Enter name of Other 32 Service:	1	
Enter name of Other 20 Service:	Enter name of Other 33 Service:	1	
Enter name of Other 21 Service:	Enter name of Other 34 Service:	1	
Enter name of Other 22 Service:	Enter name of Other 35 Service:	1	
Enter name of Other 23 Service:	Enter name of Other 36 Service:	1	
Enter name of Other 24 Service:	Enter name of Other 37 Service:	]	
Enter name of Other 25 Service:	Enter name of Other 38 Service:		
, Enter name of Other 26 Service:			

revious Next (Validate) Go To: #13h Ad	iditional Services - Base 3
there a limit on the Additional Services provided?  Yes No Select Additional Services where a limit applies: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Tobacco Cessation Counseling for Pregnant Women Freestanding Birth Center Services Respiratory Care Services Home and Community Based Services Personal Care Services Services in an Intermediate Care Facility for Individuals 65 or Older Institution for Mental Disease Services for Individuals 65 or Older Services in an Intermediate Care Facility for Individuals with Intellectual Disabiliti Case Management (Long) Term Care) Institution for Mental Disease Services for Individuals with Intellectual Disabiliti Case Management (Ong) Term Care) Other 1 Other 2 Other 3 Other 4 Other 5 Other 6 Other 7 Other 8 Other 10 Other 12 Other 13 Other 14 Other 15 Other 14 Other 15 Other 14 Other 15 Other 1 Other 20 Other 21 Other 23	Indicate units a limit will be provided in for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services: Sessions       Visits         Hours       Meals         Items/Other, Describe       Indicate numerical limit on the services provided for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:         Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:         Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:         Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:         Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:         Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:         Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:         Every day         Every month         Every Year         Every Year         Every Year         Other, Describe         Indicate units a limit will be provided in for Tobacco Cessation Counseling for Pregnant Women:         Sessions         Visits         Hours         Points         Meals         Items/Other, Describe         Indicate
	C Every week C Every month C Every year C Every Session/Visit C Every Pregnancy C Every Lifetime C Other, Describe

Previous Next (Validate) Go To: 213h	Additional Services - Base 4
ndicate units a limit will be provided in for Freestanding Birth Center Services:	Indicate units a limit will be provided in for Family Planning Services:
C Sessions	C Sessions
O Visits	C Visits
C Hours	C Hours
C Points	C Points
C Meals	C Meals
C Items/Other, Describe	C Items/Other, Describe
ndicate numerical limit on the services provided for Freestanding Birth Center Services:	Indicate numerical limit on the services provided for Family Planning Services:
Select limit on services periodicity for Freestanding Birth Center Services:	Select limit on services periodicity for Family Planning Services:
C Every day	C Every day
C Every week	C Every week
C Every month	C Every month
O Every year	C Every year
C Every Session/Visit	C Every Session/Visit
C Every Pregnancy	C Every Pregnancy
C Every Lifetime	C Every Lifetime
C Other, Describe	C Other, Describe
ndicate units a limit will be provided in for Respiratory Care Services:	Indicate units a limit will be provided in for Nursing Home Services:
C Sessions	C Sessions
C Visits	O Visits
C Hours	C Hours
C Points	C Points
C Meals	C Meals
O Items/Other, Describe	C Items/Other, Describe
ndicate numerical limit on the services provided for Respiratory Care Services:	Indicate numerical limit on the services provided for Nursing Home Services:
Select limit on services periodicity for Respiratory Care Services:	Select limit on services periodicity for Nursing Home Services:
C Every day	C Every day
C Every week	C Every week
C Every month	C Every month
C Every year	C Every year
C Every Session/Visit	C Every Session/Visit
C Every Pregnancy	C Every Pregnancy
C Every Lifetime	C Every Lifetime
C Other, Describe	C Other, Describe

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #13h Ad	iditional Services - Base 5
		(validate)	Vandatey		
ndicate units a	limit will be p	rovided in for Hon	ne and Commur	ity Based Services:	Indicate units a limit will be provided in for Self-Directed Personal Assistance Servic
Sessions Visits Hours Points Meals Items/Othe	r. Describe				C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe
Services:		e services provid		I Community Based	Indicate numerical limit on the services provided for Self-Directed Personal Assistance Services: Select limit on services periodicity for Self-Directed Personal Assistance Services:
<ul> <li>Every day</li> <li>Every week</li> <li>Every monion</li> <li>Every year</li> <li>Every Sess</li> <li>Every Preg</li> <li>Every Lifeti</li> <li>Other, Des</li> </ul>	th ion/Visit nancy ime				C Every day C Every week C Every month C Every year C Every Session/Visit C Every Pregnancy C Every Lifetime C Other, Describe
		rovided in for Pers	onal Care Serv	ces:	Indicate units a limit will be provided in for Private Duty Nursing Services:
C Sessions C Visits C Hours C Points C Meals C Items/Othe					C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe
ndicate numer	ical limit on th	e services provide	ed for Personal	Care Services:	Indicate numerical limit on the services provided for Private Duty Nursing Services:
Select limit on s	services perio	dicity for Persona	Care Services:		Select limit on services periodicity for Private Duty Nursing Services:
C Every day C Every week C Every moni C Every year C Every Sess C Every Preg C Every Lifeti C Other, Des	th ion/Visit nancy ime				C Every day C Every week C Every month C Every year C Every Session/Visit C Every Pregnancy C Every Lifetime C Other, Describe

Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	f13h Additional Services - Base 6▼
Indicate units	a limit will be p	rovided in for Cas	e Management	(Long Term C	Indicate units a limit will be provided in for Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities:
C Sessions C Visits C Hours C Points C Meals					C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe
Indicate numer Care):	Exit         Exit         Exit         Validate           cate units a limit will be provided in for Case Management (Long Term Care           Sessions           Visits           Hours           Points           Meals           Items/Other, Describe           cate numerical limit on the services provided for Case Management (Long Term Care):           Every day           Every week           Every week           Every week           Every Vear           Every Session/Visit           Every Vear           Every Session/Visit           Every Vear           Every Liftime           Other, Describe           cate units a limit will be provided in for Institution for Mental Disease Service           Visits           Hours           Points           Meals           Items/Other, Describe           cate unumerical limit on the services provided for Institution for Mental Disease Services           Points           Meals           Items/Other, Describe           cate numerical limit on the services provided for Institution for Mental Disease           cate numerical limit on the services provided for Institution for Mental Disease           rices for Indivi			agement (Loi	g Term Indicate numerical limit on the services provided for Services in an Intermediate Ca Facility for Individuals with Intellectual Disabilities:
Select limit on	services perio	dicity for Case Ma	anagement (Lon	g Term Care)	Select limit on services periodicity for Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities:
C Every Preg C Every Lifet	th sion/Visit mancy ime				C Every day C Every week C Every month C Every year C Every Session/Nisit C Every Pregnancy C Every Lifetime C Other, Describe
		rovided in for Inst	itution for Menta	I Disease Ser	ices for Indicate units a limit will be provided in for Case Management:
C Sessions C Visits C Hours C Points C Meals C Items/Othe	er, Describe				C Sessions C Visits C Hours C Pours C Meals C Items/Other, Describe
			ed for Institution	for Mental Di	Indicate numerical limit on the services provided for Case Management:
		dicity for Institutio	n for Mental Dis	ease Services	for Select limit on services periodicity for Case Management:
	th sion/Visit mancy ime				C Every day C Every week C Every month C Every year C Every Session/Nisit C Every Pregnancy C Every Lifetime C Other, Describe

Previous Next	Exit (Validate)	Exit (No Validate)	Go To: #13h Additional Services - Base 7	
ndicate units a limit will be p	rovided in for Oth	er 1:	Indicate units a limit will be provided in for Other 3:	
C Sessions			C Sessions	
C Visits			C Visits	
C Hours			C Hours	
C Points			C Points	
C Meals			C Meals	
C Items/Other, Describe			C Items/Other, Describe	
ndicate numerical limit on th	ne services provide	ed for Other 1:	Indicate numerical limit on the services provided for Other 3:	
Select limit on services perio	dicity for Other 1:		Select limit on services periodicity for Other 3:	
C Every day			C Every day	_
C Every week			C Every week	
C Every month			C Every month	
C Every year			C Every year	
C Every Session/Visit			C Every Session/Visit	
C Every Pregnancy			C Every Pregnancy	
C Every Lifetime			C Every Lifetime	
Other, Describe			C Other, Describe	
ndicate units a limit will be p	rovided in for Oth	er 2:	Indicate units a limit will be provided in for Other 4:	
C Sessions			C Sessions	
C Visits			C Visits	
C Hours			C Hours	
C Points			C Points	
C Meals			C Meals	
C Items/Other, Describe			C Items/Other, Describe	 
ndicate numerical limit on th	ne services provide	ed for Other 2:	Indicate numerical limit on the services provided for Other 4:	
Select limit on services perio	dicity for Other 2:		Select limit on services periodicity for Other 4:	
C Every day			C Every day	_
C Every week			C Every week	
C Every month			C Every month	
C Every year			C Every year	
C Every Session/Visit			C Every Session/Visit	
C Every Pregnancy			C Every Pregnancy	
			C Every Lifetime	
C Every Lifetime C Other, Describe			C Other, Describe	

t will be provided in for Other 7: escribe limit on the services provided for Other 7: ices periodicity for Other 7:
escribe limit on the services provided for Other 7:
limit on the services provided for Other 7:
limit on the services provided for Other 7:
limit on the services provided for Other 7:
limit on the services provided for Other 7:
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ices periodicity for Other 7:
ices periodicity for Other 7:
Visit
cy
e
it will be provided in for Other 8:
escribe
limit on the services provided for Other 8:
ices periodicity for Other 8:
Visit
-,
e
e ibe

provided in for Other 9:		Indicate units a limit will be provided in for Other 11:
		C Sessions
		C Visits
		C Hours
		C Points
		C Meals
		C Items/Other, Describe
he services provided for	Other 9:	Indicate numerical limit on the services provided for Other 11:
odicity for Other 9:		Select limit on services periodicity for Other 11:
		C Every day
		C Every week
		C Every month
		C Every year
		C Every Session/Visit
		C Every Pregnancy
		C Every Lifetime
		C Other, Describe
provided in for Other 10:		Indicate units a limit will be provided in for Other 12:
		C Sessions
		C Visits
		C Hours
		C Points
		C Meals
		C Items/Other, Describe
the services provided for	Other 10:	Indicate numerical limit on the services provided for Other 12:
odicity for Other 10:		Select limit on services periodicity for Other 12:
		C Every day
		C Every week
		C Every month
		C Every year
		C Every Session/Visit
		C Every Pregnancy C Every Lifetime
		O Other, Describe
	provided in for Other 10:	provided in for Other 10: the services provided for Other 10:

Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #13h Additional Services - Base 10	•	
Indicate units a lin	nit will be pr	ovided in for Oth	er 13:	Indicate units a limit will be provided in for Other 15:		
C Sessions C Visits C Hours				C Sessions C Visits C Hours		
C Points C Meals C Items/Other, D	acariba			C Points C Meals C Items/Other, Describe		
Indicate numerica		e services provide	ed for Other 13:	Indicate numerical limit on the services provided for Other 15:		
Select limit on ser		dicity for Other 13		Select limit on services periodicity for Other 15:		
C Every day C Every week C Every month C Every year C Every year C Every Pregnal C Every Lifetime C Other, Descril	n/Visit ncy	aicity for Other 13	c	C Every day C Every week C Every week C Every week C Every year C Every Session/Visit C Every Pregnancy C Every Lifetime C Other, Describe		
Indicate units a lin	nit will be pr	ovided in for Oth	er 14:	Indicate units a limit will be provided in for Other 16:		
C Sessions C Visits C Hours C Points C Meals C Items/Other, E Indicate numerica		e services provide	ed for Other 14:	C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe		
Select limit on ser	vices perior	dicity for Other 14		Select limit on services periodicity for Other 16:		
C Every day C Every week C Every week C Every month C Every year C Every Sessior C Every Pregna C Every Lifetime O Other, Descrii	n/Visit ncy		•	C Every day C Every week C Every week C Every year C Every year C Every Pregnancy C Every Lifetime C Other, Describe		

Previous Next	Exit (Validate)	Exit (No Validate)	Go To: #13h Additional Services - Base 11	
ndicate units a limit will b	e provided in for Oth	er 17:	Indicate units a limit will be provided in for Other 19:	_
C Sessions			C Sessions	
C Visits			C Visits	
C Hours			O Hours	
C Points			C Points	
C Meals			O Meals	
C Items/Other, Describe			C Items/Other, Describe	
ndicate numerical limit o	n the services provide	ed for Other 17:	Indicate numerical limit on the services provided for Other 19:	
Calaat limit on annuinen n	sig digity for Other 17		Calact limit an environmentalisity for Other 10	
Select limit on services po	anouncity for Other 17		Select limit on services periodicity for Other 19:	
C Every week			C Every day	
C Every week			C Every week	
C Every year			C Every work	
C Every Session/Visit			C Every Session/Visit	
C Every Pregnancy			C Every Pregnancy	
C Every Lifetime			C Every Lifetime	
O Other, Describe			O Other, Describe	
				 _
ndicate units a limit will b	e provided in for Oth	er 18:	Indicate units a limit will be provided in for Other 20:	
C Sessions C Visits			C Sessions C Visits	
C Hours			C Hours	
C Points			C Points	
C Meals			C Meals	
C Items/Other, Describe			C Items/Other, Describe	_
ndicate numerical limit o	n the services provide	ed for Other 18:	Indicate numerical limit on the services provided for Other 20:	
Select limit on services p	eriodicity for Other 18	E	Select limit on services periodicity for Other 20:	
C Every day			C Every day	
C Every week			C Every week	
C Every month			C Every month	
C Every year			C Every year	
C Every Session/Visit			C Every Session/Visit	
C Every Pregnancy			C Every Pregnancy	
			C Every Lifetime	
C Every Lifetime			C Other, Describe	

Indicate units a limit will be provided in for Other 23: C Sessions C Visits C Hours C Meals C Items/Other, Describe Indicate numerical limit on the services provided for Other 23: Select limit on services periodicity for Other 23:
C Sessions Visits Hours C Points Meals C Items/Other, Describe Indicate numerical limit on the services provided for Other 23:
Visits     Hours     Points     Meals     Indicate numerical limit on the services provided for Other 23:
Points     Meals     Items/Other, Describe  Indicate numerical limit on the services provided for Other 23:
Meals     Tems/Other, Describe  Indicate numerical limit on the services provided for Other 23:
C Items/Other, Describe Indicate numerical limit on the services provided for Other 23:
Indicate numerical limit on the services provided for Other 23:
Select limit on services periodicity for Other 23:
Select limit on services periodicity for Other 23:
C Every day
C Every week
C Every month
C Every year
C Every Session/Visit
C Every Pregnancy
C Every Lifetime
C Other, Describe
Indicate units a limit will be provided in for Other 24:
C Sessions
C Visits
C Hours
C Points
C Meals
C Items/Other, Describe
Indicate numerical limit on the services provided for Other 24:
Select limit on services periodicity for Other 24:
C Every day
C Every week
C Every month
C Every year
C Every Session/Visit
C Every Pregnancy C Every Lifetime
C Other, Describe

ndicate units a lin O Sessions O Visits			Validate)			
C Sessions	nit will be pr	ovided in for Oth	er 25:	Indicate units a limit will be provided in for Other 27:		
	in min be pr		0120.	© Sessions		
				O Visits		
C Hours				O Hours		
C Points				C Points		
C Meals				C Meals		
C Items/Other, D	escribe			C Items/Other, Describe		
ndicate numerica	l limit on the	e services provide	ed for Other 25:	Indicate numerical limit on the services provided for Other 27:		
Select limit on ser	vices perio	dicity for Other 25	8	Select limit on services periodicity for Other 27:		
C Every day				C Every day		
C Every week				C Every week		
C Every month				C Every month		
C Every year				C Every year		
C Every Session	Nisit			C Every Session/Visit		
C Every Pregna	ncy			C Every Pregnancy		
C Every Lifetime				C Every Lifetime		
C Other, Descrit	be			C Other, Describe		
ndicate units a lin	nit will be pr	ovided in for Oth	er 26:	Indicate units a limit will be provided in for Other 28:		
C Sessions				C Sessions		
C Visits				C Visits		
C Hours				C Hours		
C Points				C Points		
C Meals				C Meals		
C Items/Other, D	escribe			C Items/Other, Describe		_
ndicate numerica	l limit on the	e services provide	ed for Other 26:	Indicate numerical limit on the services provided for Other 28:		
Select limit on ser	vices perio	dicity for Other 26	5	Select limit on services periodicity for Other 28:		
C Every day				C Every day	 	_
C Every week				C Every week		
C Every month				C Every month		
C Every year				C Every year		
C Every Session				C Every Session/Visit		
C Every Pregna				C Every Pregnancy		
C Every Lifetime				C Every Lifetime		
C Other, Descrit	be			C Other, Describe		_

Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #13h Additional Services - Base 14	-	1	
Indicate units a	a limit will be pr	rovided in for Oth	er 29:	Indicate units a limit will be provided in for Other 31:			
C Sessions				C Sessions			
C Visits				C Visits			
C Hours				C Hours			
C Points				C Points			
C Meals				C Meals			
C Items/Othe	er, Describe			C Items/Other, Describe			
Indicatenumer	rical limit on th	e services provide	ed for Other 29:	Indicate numerical limit on the services provided for Other 31:			
		dicity for Other 29	):	Select limit on services periodicity for Other 31:			
C Every day				C Every day			
C Every week				C Every week			
C Every mon				C Every month			
C Every year				C Every year			
C Every Sess				C Every Session/Visit			
C Every Preg				C Every Pregnancy			
C Every Lifeti				C Every Lifetime			
C Other, Des	cribe			C Other, Describe			
	a limit will be pr	rovided in for Oth	er 30:	Indicate units a limit will be provided in for Other 32:			
C Sessions				C Sessions			
C Visits				C Visits			
C Hours				C Hours			
C Points				C Points			
C Meals				C Meals			
C Items/Othe	r, Describe			C Items/Other, Describe			_
Indicate numer	rical limit on th	e services provide	ed for Other 30:	Indicate numerical limit on the services provided for Other 32:			
Select limit on s	services perio	dicity for Other 30		Select limit on services periodicity for Other 32:			
C Every day				C Every day			_
C Every week	k			C Every week			
C Every mon	th			C Every month			
C Every year				C Every year			
C Every Sess	sion/Visit			C Every Session/Visit			
C Every Preg	nancy			C Every Pregnancy			
C Every Lifeti				C Every Lifetime			
C Other, Des	cribe			C Other, Describe			

Previous Next	Exit (Validate)	Exit (No Validate)	Go To: #13h Additional Services - Base 15	
ndicate units a limit will be	provided in for Oth	er 33:	Indicate units a limit will be provided in for Other 35:	
C Sessions			C Sessions	
C Visits			C Visits	
C Hours			C Hours	
C Points			C Points	
C Meals			C Meals	
C Items/Other, Describe			C Items/Other, Describe	
ndicate numerical limit on	the services provid	ed for Other 33:	Indicate numerical limit on the services provided for Other 35:	
Select limit on services per	iodicity for Other 33	3:	Select limit on services periodicity for Other 35:	
C Every day			C Every day	
C Every week			C Every week	
C Every month			C Every month	
C Every year			C Every year	
C Every Session/Visit			C Every Session/Visit	
C Every Pregnancy			C Every Pregnancy	
C Every Lifetime C Other, Describe			C Every Lifetime C Other, Describe	
				-
ndicate units a limit will be	provided in for Oth	er 34:	Indicate units a limit will be provided in for Other 36:	
C Sessions			C Sessions	
C Visits			○ Visits	
C Hours			C Hours	
C Points			C Points	
C Meals			C Meals	
C Items/Other, Describe			C Items/Other, Describe	_
ndicate numerical limit on	the services provid	ed for Other 34:	Indicate numerical limit on the services provided for Other 36:	
Select limit on services pe	iodicity for Other 34	ł:	Select limit on services periodicity for Other 36:	
C Every day			C Every day	
C Every week			C Every week	
C Every month			C Every month	
C Every year			C Every year	
C Every Session/Visit			C Every Session/Visit	
C Every Pregnancy			C Every Pregnancy	
C Every Lifetime			C Every Lifetime	
C Other, Describe			C Other, Describe	

Help	Exit	Exit (No	Go To: #13h Additional Services - Base 16	•
revious Ne	ct (Validate)	Validate)		
dicate units a limit wi	I be provided in for Oth	her 37:		
Sessions				
Visits				
Hours				
Points				
Meals				
Items/Other, Descr				
idicate numerical limit	on the services provid	ded for Other 37:		
elect limit on services	periodicity for Other 3	7:		
C Every day				
Every week				
Every month				
Every year				
<ul> <li>Every Session/Visi</li> <li>Every Pregnancy</li> </ul>				
C Every Lifetime				
Other, Describe				
ndicate units a limit wi	I be provided in for Oth	her 38:		
C Sessions	una del Clonic Statistica de C.S.			
O Visits				
Hours				
O Points				
Meals				
C Items/Other, Descr				
ndicate numerical limit	on the services provid	ted for Other 38:		
	periodicity for Other 3	8:		
C Every day C Every week				
Every week Every month				
C Every year				
Every Session/Visi	t			
Every Pregnancy				
Every Lifetime				
Other, Describe				

there a Maximum Plan	n Benefit Amount for Additio	onal Services?	Indicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amoun
O Yes O No			for EPSDT:	for RCS:
Select which Additio Amount (Select all th	nal Services have a Maxim at apply):	um Plan Benefit Coverage	Select Maximum Plan Benefit Coverage Periodicity EPSDT:	Select Maximum Plan Benefit Coverage Periodicity RCS:
Early and Periodic Sc Tobacco Cessation C Freestanding Birth Ce Respiratory Care Ser Family Planning Servi Nursing Home Servic Home and Community Personal Care Servic	reening, Diagnostic, and Tree ounseling for Pregnant Wom- inter Services vices ces es Based Services		C Every three years C Every two years C Every year C Every six months C Every six months C Other, Describe Indicate Maximum Plan Benefit Amount for TCCPW:	C Every three years C Every two years C Every year C Every six months C Every six months C Other, Describe Indicate Maximum Plan Benefit Amount for FPS:
Private Duty Nursing Case Management (L Institution for Mental D	Services ong Term Care) Disease Services for Individu		Select Maximum Plan Benefit Coverage Periodicity TCCPW:	Select Maximum Plan Benefit Coverage Periodicity FPS:
Services in an Interm Case Management Other 1 Other 2 Other 3 Other 4 Other 5 Other 6	ediate Care Facility for Individ	uais with Intellectual Disabilit	C Every three years C Every two years C Every year C Every year C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Other, Describe
Other 7 Other 8 Other 9			Indicate Maximum Plan Benefit Amount for FBCS:	Indicate Maximum Plan Benefit Amoun for NHS:
Other 10 Other 11 Other 12			Select Maximum Plan Benefit Coverage Periodicity FBCS:	Select Maximum Plan Benefit Coverage Periodicity NHS:
Other 13 Other 14 Other 15 Other 16 Other 16 Other 17 Other 18 Other 19 Other 20 Other 21 Other 22		v	C Every three years Every two years Every year Every six months Every three months Other, Describe	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe

Select Maximum Plan Benefit Coverage Periodicity HCBS: C Every three years	Select Maximum Plan Benefit Coverage Periodicity PDNS:	Select Maximum Plan Benefit	Select Maximum Plan Benefit
		Coverage Periodicity SICFID:	Coverage Periodicity OTHER2:
C Every two years C Every year C Every six months C Every three months O Other, Describe	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Other, Describe
dicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amoun
PCS:	for CM_LTC:	for CM:	for OTHER3:
Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit
Coverage Periodicity PCS:	Coverage Periodicity CM_LTC:	Coverage Periodicity CM:	Coverage Periodicity OTHER3:
C Every three years	C Every three years	C Every three years	C Every three years
C Every two years	C Every two years	C Every two years	C Every two years
C Every year	C Every year	C Every year	C Every year
C Every six months	C Every six months	C Every six months	C Every six months
C Every three months	C Every three months	C Every three months	C Every three months
C Other, Describe	C Other, Describe	C Other, Describe	C Other, Describe
dicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amoun
r SDPAS:	for IMDS:	for OTHER1:	for OTHER4:
Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit
Coverage Periodicity SDPAS:	Coverage Periodicity IMDS:	Coverage Periodicity OTHER1:	Coverage Periodicity OTHER4:
C Every three years	C Every three years	C Every three years	C Every three years
C Every two years	Every two years	C Every two years	C Every two years
C Every year	Every year	C Every year	C Every year
C Every six months	Every six months	C Every six months	C Every six months
C Every three months	Every three months	C Every three months	C Every three months
C Other, Describe	Other, Describe	C Other, Describe	C Other, Describe

Select Maximum Plan Benefit Coverage Periodicity OTHERS:       Select Maximum Plan Benefit Coverage Periodicity OTHER1:       Select Maximum Plan Benefit Coverage Periodicity OTHER1:       Select Maximum Plan Benefit Coverage Periodicity OTHER1:       Cevery three years         © Every three years       © Every three months       © Other, Describe       Indicate Maximum Plan Benefit Amount for OTHER9:       Indicate Maximum Plan Benefit Coverage Periodicity OTHER12:       Select Maximum Plan Benefit       Select Maximum Plan Benefit       Select Maximum Plan Benefit       Coverage Periodicity OTHER15:       Select Maximum Plan Benefit       © Every three years	dicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amount for OTHER8:	Indicate Maximum Plan Benefit Amount for OTHER11:	Indicate Maximum Plan Benefit Amount for OTHER14:
Coverage Periodicity OTHER5:       Coverage Periodicity OTHER1:	I OTHERS.			
C       Every two years       C       Every three months       C       Other, Describe       Indicate Maximum Plan Benefit       Coverage Periodicity OTHER12:       Indicate Maximum Plan Benefit       Coverage Periodicity OTHER12:       C       Every two years       C				
Select Maximum Plan Benefit Coverage Periodicity OTHER6:       Select Maximum Plan Benefit Coverage Periodicity OTHER12:       Select Maximum Plan Benefit Coverage Periodicity OTHER13:       Indicate Maximum Plan Benefit Coverage Periodicity OTHER13:       Indicate Maximum Plan Benefit Coverage Periodicity OTHER13:       Indicate Maximum Plan Benefit Coverage Periodicity OTHER13:       Select Maximum Plan Benefit Coverage Pe	C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every two years C Every year C Every six months C Every three months
Coverage Periodicity OTHER8:       Coverage Periodicity OTHER9:       Coverage Periodicity OTHER12:       Coverage Periodicity OTHER15:         © Every three years       © Every three months       © Other, Describe       Indicate Maximum Plan Benefit Amount for OTHER10:       Indicate Maximum Plan Benefit Amount for OTHER13:       Indicate Maximum Plan Benefit       Indicate Maximum Plan Benefit       Select Maximum Plan Benefit       Coverage Periodicity OTHER13:       Select Maximum Plan Benefit         Coverage Periodicity OTHER7:       Select Maximum Plan Benefit       Select Maximum Plan Benefit       Select Maximum Plan Benefit       Coverage Periodicity OTHER13:       Select Maximum Plan Benefit         Coverage Periodicity OTHER7:       Select Maximum Plan Benefit       Select Maximum Plan Benefit       Coverage Periodicity OTHER13:       Select Maximum Plan Benefit         C Every three years       © Every three years       © Every three ye				
C       Every two years       E       C       Every two years       E       Every two years       E       E       Every two years       C				
or OTHER7:       for OTHER10:       for OTHER13:       for OTHER16:         Select Maximum Plan Benefit Coverage Periodicity OTHER7:       Select Maximum Plan Benefit Coverage Periodicity OTHER10:       Select Maximum Plan Benefit Coverage Periodicity OTHER13:       Select Maximum Plan Benefit Coverage Periodicity OTHER16:         C Every three years         C Every year       C Every year       C Every year       C Every six months       C Every six months	C Every two years Every year Every six months Every three months	C Every two years C Every year C Every six months C Every three months	C Every two years C Every year C Every six months C Every three months	C Every two years C Every year C Every six months C Every three months
Coverage Periodicity OTHER7:         Coverage Periodicity OTHER10:         Coverage Periodicity OTHER13:         Coverage Periodicity OTHER13:           C Every three years         C Every two years         C Every two years         C Every two years         C Every year         C Every six months				Indicate Maximum Plan Benefit Amount for OTHER16:
C         Every two years         C         Every year         C         Every year         C         Every year         C         Every year         C         Every six months				
C Every three months     C Every three months     C Every three months     C Every three months       C Other, Describe     C Other, Describe     C Other, Describe	C Every two years Every year Every six months Every three months	C Every two years C Every year C Every six months C Every three months	C Every two years C Every year C Every six months C Every three months	C Every two years C Every year C Every six months C Every three months

revious Next (Validate	Exit (No	tional Services - Base 20	<u> </u>
dicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amoun
r OTHER17:	for OTHER20:	for OTHER23:	for OTHER26:
Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit
Coverage Periodicity OTHER17:	Coverage Periodicity OTHER20:	Coverage Periodicity OTHER23:	Coverage Periodicity OTHER26:
C Every three years C Every two years C Every year C Every six months C Every six months C Every six months C Every three months C Other, Describe dicate Maximum Plan Benefit Amount r OTHER18:	C Every three years C Every two years C Every year C Every six months C Every six months C Other, Describe Indicate Maximum Plan Benefit Amount for OTHER21:	C Every three years C Every two years C Every year C Every six months C Every six months C Other, Describe Indicate Maximum Plan Benefit Amount for OTHER24:	C Every three years C Every two years C Every year C Every six months C Every six months C Other, Describe Indicate Maximum Plan Benefit Amoun for OTHER27:
Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit
Coverage Periodicity OTHER18:	Coverage Periodicity OTHER21:	Coverage Periodicity OTHER24:	Coverage Periodicity OTHER27:
C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe
dicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amoun
r OTHER19:	for OTHER22:	for OTHER25:	for OTHER28:
Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit
Coverage Periodicity OTHER19:	Coverage Periodicity OTHER22:	Coverage Periodicity OTHER25:	Coverage Periodicity OTHER28:
C Every three years	C Every three years	C Every three years	C Every three years
C Every two years	Every two years	C Every two years	C Every two years
C Every year	Every year	C Every year	C Every year
C Every six months	Every six months	C Every six months	C Every six months
C Every three months	Every three months	C Every three months	C Every three months
C Other, Describe	O Other, Describe	C Other, Describe	C Other, Describe

or OTHER29:	for OTHER32:	for OTHER35:	for OTHER38:
Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit
Coverage Periodicity OTHER29:	Coverage Periodicity OTHER32:	Coverage Periodicity OTHER35:	Coverage Periodicity OTHER38:
C Every three years	C Every three years	C Every three years	C Every three years
C Every two years	C Every two years	C Every two years	C Every two years
C Every year	C Every year	C Every year	C Every year
C Every six months	C Every six months	C Every six months	C Every six months
C Every three months	C Every three months	C Every three months	C Every three months
C Other, Describe	C Other, Describe	C Other, Describe	C Other, Describe
dicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amount	
r OTHER30:	for OTHER33:	for OTHER36:	
Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit	
Coverage Periodicity OTHER30:	Coverage Periodicity OTHER33:	Coverage Periodicity OTHER36:	
C Every three years	C Every three years	C Every three years	
C Every two years	C Every two years	C Every two years	
C Every year	C Every year	C Every year	
C Every six months	C Every six months	C Every six months	
C Every three months	C Every three months	C Every three months	
C Other, Describe	C Other, Describe	C Other, Describe	
dicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amount	Indicate Maximum Plan Benefit Amount	
or OTHER31:	for OTHER34:	for OTHER37:	
Select Maximum Plan Benefit	Select Maximum Plan Benefit	Select Maximum Plan Benefit	
Coverage Periodicity OTHER31:	Coverage Periodicity OTHER34:	Coverage Periodicity OTHER37:	
C Every three years	C Every three years	C Every three years	
C Every two years	Every two years	C Every two years	
C Every year	Every year	C Every year	
C Every six months	Every six months	C Every six months	
C Every three months	Every three months	C Every three months	
C Other, Describe	O Other, Describe	C Other, Describe	

•		Exit	Exit (No	Go To: #13h Add	itional Services - Base 22
		(Validate)	Validate) enrollment in a s		Is a beneficiary receiving any benefit subject to a state-required monthly payment amount tha
Paiver program					based on his or her financial resources (for example: a "patient pay amount")? C Yes C No Select herefits subject to a state serviced monthly payment amount that is based on his o
waiver pro Early and F Tobacco C Freestandi Respirator Family Plan Nursing Ho Home and Personal C Self-Direct Private Dut Case Mana Institution f	gram: Periodic Screen essation Courn- ing Birth Center y Care Services aning Services Community Bas community Bas are Services ed Personal As ty Nursing Serv agement (Long for Mental Dise: n an Intermedial	ing, Diagnostic, an seling for Pregnant Services s sed Services sistance Services rices Term Care) ase Services for In	d Treatment (EP: Women dividuals 65 or C		Select benefits subject to a state-required monthly payment amount that is based on his o financial resources (for example: a "patient pay amount)": Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Tobacco Cessation Counseling for Pregnant Women Freestanding Bith Center Services Respiratory Care Services Nursing Home Services Nursing Home Services Self-Directed Personal Assistance Services Private Dury Nursing Services Case Management (Long Term Care) Institution for Mental Disease Services for Individuals 65 or Older Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities Case Management Other 1 Other 2 Other 3 Other 4 Other 5 Other 6 Other 7 Other 8 Other 10 Other 11 Other 13 Other 14 Other 13 Other 16 Other 16 Other 17 Other 18 Other 20 Other 23

•		Exit	Exit (No	Go To:	#13h Additional Services	- Base 23		•
revious	Next	(Validate)	Validate)		_	_	_	_
nter minimum uidance on wi	and maximum hat values to e	n values only if instr enter, leave the mini	ructed to do so imum and max	by the State mum fields t		vide		
			Minimum Patient Pay Amount		Maximum Patient Pay Amount		Minimum Patient Pay Amount	Maximum Patient Pay Amount
arly and Perio reatment (EPS		, Diagnostic, and				Case Management		
obacco Cessa Vomen	tion Counseli	ng for Pregnant				Other 1		
reestanding B	lirth Center Se	rvices				Other 2		
Respiratory Ca	re Services					Other 3		
Family Plannin	g Services					Other 4		
Nursing Home	Services					Other 5		
Home and Con	munity Based	Services				Other 6		
Personal Care	Services					Other 7		
Self-Directed P	ersonal Assis	tance Services				Other 8		
Private Duty Nu	rsing Service	s				Other 9		
Case Managem	ient (Long Te	rm Care)				Other 10		
nstitution for N ndividuals 65 o		Services for				Other 11		
	Intermediate C	Care Facility for				Other 12		

evious	Next	Exit (Validate)	Exit (No Validate)	Go To:	#13h Addition	al Services - Base 24		_	
ter minimum	and maximum	values only if i	nstructed to do so	by the State	e. If your state d	id not provide			
dance on w	Minimum Patient Pay Amount	nter, leave the	minimum and max Maximum Patient Pay Amount	imum tields	DIANK.	Minimum Patient Pay Amount	Maximum Patient Pay Amount		
ner 13					Other 26				
ner 14					Other 27				
ner 15					Other 28				
ner 16					Other 29				
ner 17					Other 30				
ner 18					Other 31				
ner 19					Other 32				
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ner 21					Other 34				
ner 22					Other 35				
ner 23					Other 36				
ner 24					Other 37				
ner 25					Other 38				

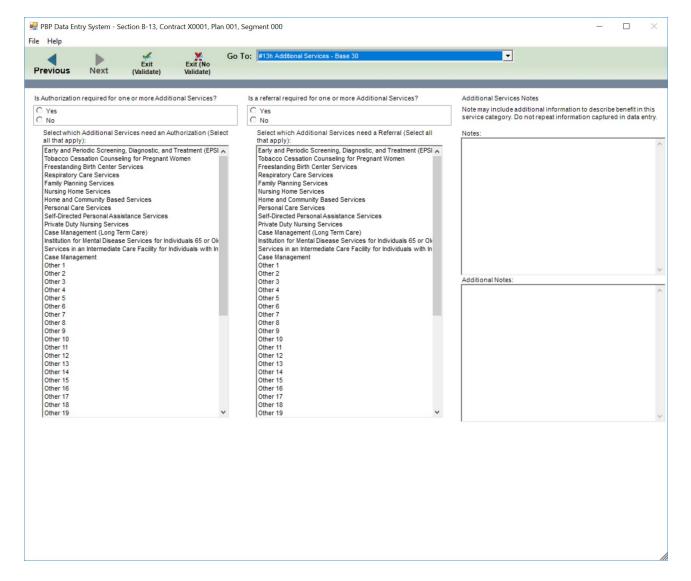
revious Next (Validate) Go To:	13h Additional Services - Base 25	<b>_</b>
Exit Exit No     Exit Exit No     Validate)      umust include total cost sharing to the beneficiary, including any facility cos     aring. If you have a variety of cost sharing, please utilize the minimum and     ximum fields to reflect the lowest and highest cost sharing that a beneficiar     ay pay.     there an enrollee Coinsurance?     Yes     No     elect which Additional Services have a Coinsurance (Select all that apply):	t Indicate Coinsurance for one or more of the follow	ing services.

ndicate Coinsuran	Vext	Exit (Validate)	Exit (No Validate)	Go To: #13h Add	tional Services - Base 26	
			ximum		Minimum Maximum Coinsurance Coinsurance	
Case Management	Γ			Other 13		
Other 1	ſ			Other 14		
Other 2	ſ			Other 15		
Other 3	ſ			Other 16		
Other 4	ſ			Other 17		
Other 5	ſ			Other 18		
Other 6	ſ			Other 19		
Other 7	ſ			Other 20		
Other 8	ſ			Other 21		
Other 9	ſ			Other 22		
Other 10	ſ			Other 23		
Other 11	ſ			Other 24		
Other 12	ſ			Other 25		

Indicate Coinsurance for one or more of the following services. Is there an enrollee Copayment?          Minimum       Maximum         Cinsurance       Coinsurance         Other 26       Select which Additional Services have a Copayment (Select all that apply):         Enty and Periodic Screening Diapnositic, and Treatment (EPSDT) Services         Other 27       Freestanding Bith Center Services         Other 28       Freestanding Bith Center Services         Other 29       Freestanding Bith Center Services         Other 30       Freestanding Services         Other 31       Case Management (Long Term Care)         Other 32       Freestanding Services         Other 33       Other 34         Other 36       Other 30         Other 37       Other 30         Other 38       Other 30	Minimum Coinsurance       Maximum Coinsurance         Other 26       Select which Additional Services have a Copayment (Select all that apply):         Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services       Tobacco Cessation Counseling for Pregnant Women Freestanding Birth Center Services         Other 27       Respiratory Care Services       Freestanding Birth Center Services         Other 28       Respiratory Care Services         Other 29       Select Which Additional Services         Normal Care Services       Home and Community Based Services         Home and Community Based Services       Personal Care Services         Other 30       Case Management (Long Term Care) Institution for Mental Disease Services for Individuals 65 or Older         Services in an Intermediate Care Facility for Individuals 65 or Older       Services in an Intermediate Care Facility for Individuals 65 or Older         Other 31       Case Management       Other 1         Other 32       Other 4       Other 3         Other 34       Other 7       Other 8         Other 35       Other 10       Other 10         Other 36       Other 11       Other 13         Other 38       Other 16       Other 16         Other 17       Other 18       Other 19         Other 18       Other 17       Other 18	
Minimum Coinsurance       Maximum Coinsurance         Other 28       Select which Additional Services have a Copayment (Select all that apply):         Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services       •         Tobacco Cessation Counseling for Pregnant Women Freestanding Bith Center Services       •         Other 28       •       •         Other 29       •       •         Other 30       •       •         Other 31       •       •         Other 32       •       •         Other 33       •       •         Other 34       •       •         Other 35       •       •         Other 38       •       •         Other 38       •       •         Other 38       •       •	Minimum Coinsurance       Maximum Coinsurance         Other 26       Select which Additional Services have a Copayment (Select all that apply):         Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services       Tobacco Cessation Counseling for Pregnant Women Freestanding Birth Center Services         Other 27       Respiratory Care Services       Freestanding Birth Center Services         Other 28       Respiratory Care Services         Other 29       Select Which Additional Services         Normal Care Services       Home and Community Based Services         Home and Community Based Services       Personal Care Services         Other 30       Case Management (Long Term Care) Institution for Mental Disease Services for Individuals 65 or Older         Services in an Intermediate Care Facility for Individuals 65 or Older       Services in an Intermediate Care Facility for Individuals 65 or Older         Other 31       Case Management       Other 1         Other 32       Other 4       Other 3         Other 34       Other 7       Other 8         Other 35       Other 10       Other 10         Other 36       Other 11       Other 13         Other 38       Other 16       Other 16         Other 17       Other 18       Other 19         Other 18       Other 17       Other 18	
Other 26       Early and Periodic Screenin, Diagnostic, and Treatment (EPSDT) Services         Other 27       Tobacco Cessation counseling for Pregnant Women         Freestanding Birth Center Services       Respiratory Care Services         Respiratory Care Services       Nursing Home Services         Other 28       Nursing Home Services         Other 29       Services         Other 30       Services         Other 31       Care Services         Other 32       Other 31         Other 32       Other 32         Other 33       Other 34         Other 34       Other 36         Other 35       Other 10         Other 36       Other 37         Other 37       Other 10         Other 38       Other 10         Other 38       Other 10	Other 26       Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services         Other 27       Freestanding Birth Center Services         Other 28       Framily Planning Services         Other 29       Personal Care Services         Other 30       Personal Care Services         Other 31       Case Management (Long Term Care)         Institution for Mental Disease Services for Individuals 65 or Older         Services in an Intermediate Care Facility for Individuals Sor Older         Other 32       Other 3         Other 33       Other 4         Other 36       Other 7         Other 37       Other 10         Other 13       Other 14         Other 36       Other 12         Other 37       Other 14         Other 38       Other 12         Other 13       Other 14         Other 14       Other 15         Other 15       Other 14	
Other 27       Freestanding Birth Center Services         Respiratory Care Services       Respiratory Care Services         Other 28       Nursing Home Services         Other 29       SetFichTome Services         Other 30       SetFichTome Services         Other 31       SetFichTome Services for Individuals 65 or Older         SetFichTome Services       SetVices for The Services for Individuals 65 or Older         Other 31       Services in an Intermediate Care Facility for Individuals 65 or Older         Other 32       Other 1         Other 33       Other 4         Other 34       Other 5         Other 35       Other 6         Other 36       Other 7         Other 37       Other 10         Other 38       Other 11         Other 38       Other 12         Other 38       Other 11         Other 38       Other 11	Other 27       Freestanding Birth Center Services         Respiratory Care Services       Respiratory Care Services         Other 28       Nursing Home Services         Other 29       Self-Directed Personal Care Services         Other 30       Case Management (Long Term Care)         Institution for Mental Disease Services for Individuals 65 or Older         Services in an Intermediate Care Facility for Individuals of Older         Other 31       Case Management (Long Term Care)         Institution for Mental Disease Services for Individuals of Older         Services in an Intermediate Care Facility for Individuals of Older         Other 31       Case Management (Long Term Care)         Institution for Mental Disease Services for Individuals of Older         Services in an Intermediate Care Facility for Individuals with Intellectual Disability         Case Management         Other 32         Other 33         Other 4         Other 4         Other 5         Other 6         Other 7         Other 9         Other 10         Other 13         Other 14         Other 15         Other 16         Other 18         Other 19         Other 19         Other 19	
Dther 28       Nursing Home Services         Home and Community Based Services         Personal Care Services         Self-Directed Personal Assistance Services         Private Duty Nursing Services         Case Management (Long Term Care)         Institution for Mental Disease Services for Individuals 65 or Older         Deter 31       Case Management         Other 32       Other 1         Deter 33       Other 4         Other 34       Other 5         Other 35       Other 7         Other 36       Other 10         Other 13       Other 14         Other 14       Other 16         Other 13       Other 7         Other 34       Other 7         Other 35       Other 10         Other 13       Other 11         Other 13       Other 13         Other 14       Other 14         Other 13       Other 11         Other 14       Other 18         Other 18       Other 18         Other 18       Other 19         Other 19       Other 12         Other 12       Other 12         Other 12       Other 12         Other 12       Other 12         Other 12       O	Dther 28       Nursing Home Services         Home and Community Based Services         Personal Care Services         Self-Directed Personal Assistance Services         Private Duty Nursing Services         Case Management (Long Term Care)         Institution for Mental Disease Services for Individuals 65 or Older         Services in an Intermediate Care Facility for Individuals 65 or Older         Services in an Intermediate Care Facility for Individuals 65 or Older         Other 31       Other 1         Other 32       Other 1         Other 33       Other 4         Other 4       Other 6         Other 5       Other 7         Other 7       Other 9         Other 10       Other 11         Other 13       Other 12         Other 14       Other 13         Other 15       Other 16         Other 18       Other 18         Other 19       Other 12         Other 12       Other 12         Other 12       Other 14         Other 18       Other 19         Other 19       Othe	
Dther 29       Personal Care Services         Self-Directed Personal Assistance Services       Self-Directed Personal Assistance Services         Dther 30       Case Management (Long Term Care)         Institution for Mental Disease Services for Individuals 65 or Older         Services in an Intermediate Care Facility for Individuals with Intellectual Disability         Case Management       Other 1         Dther 32       Other 1         Other 33       Other 4         Other 34       Other 6         Other 35       Other 7         Other 36       Other 10         Other 37       Other 10         Other 13       Other 13         Other 38       Other 14         Other 13       Other 13         Other 36       Other 14         Other 13       Other 13         Other 14       Other 13         Other 13       Other 14         Other 14       Other 16         Other 18       Other 19         Other 19       Other 18         Other 19       Other 19         Other 12       Other 11	Dther 29       Personal Care Services         Self-Directed Personal Assistance Services       Self-Directed Personal Assistance Services         Dther 30       Case Management (Long Tern Care)         Institution for Mental Disease Services for Individuals 65 or Older         Services in an Intermediate Care Facility for Individuals of Older         Other 31       Case Management         Other 32       Other 1         Other 33       Other 4         Other 4       Other 6         Other 7       Other 7         Other 9       Other 10         Other 11       Other 12         Other 13       Other 14         Other 14       Other 14         Other 15       Other 16         Other 18       Other 18         Other 19       Other 18         Other 12       Other 18         Other 18       Other 19	
Other 30       Case Management (Long Tem Care)         Institution for Mental Disease Services for Individuals 65 or Older         Services in an Intermediate Care Facility for Individuals with Intellectual Disability         Case Management         Other 32         Other 32         Other 33         Other 4         Other 5         Other 5         Other 7         Other 7         Other 8         Other 9         Other 10         Other 11         Other 13         Other 14         Other 13         Other 14         Other 14         Other 15         Other 16         Other 18         Other 19         Other 20         Other 21	Other 30       Case Management (Long Term Care)         Institution for Mental Disease Services for Individuals 65 or Older         Services in an Intermediate Care Facility for Individuals with Intellectual Disabilitie         Case Management         Other 31         Other 32         Other 33         Other 4         Other 5         Other 6         Other 7         Other 8         Other 9         Other 10         Other 13         Other 14         Other 15         Other 16         Other 17         Other 18         Other 18         Other 18         Other 18         Other 18         Other 19         Other 19	
Other 31       Case Management         Other 1       Other 3         Other 33       Other 4         Other 33       Other 4         Other 34       Other 5         Other 35       Other 6         Other 36       Other 10         Other 37       Other 12         Other 38       Other 15         Other 16       Other 19         Other 18       Other 10         Other 19       Other 11         Other 20       Other 12	Other 31       Case Management         Other 1       Other 2         Other 32       Other 3         Other 33       Other 4         Other 34       Other 6         Other 4       Other 7         Other 5       Other 7         Other 6       Other 7         Other 7       Other 7         Other 8       Other 10         Other 11       Other 11         Other 12       Other 13         Other 13       Other 14         Other 16       Other 16         Other 17       Other 18         Other 19       Other 19         Other 19       Other 10	
Other 32       Other 2         Other 33       Other 3         Other 34       Other 5         Other 35       Other 7         Other 36       Other 10         Other 12       Other 13         Other 37       Other 15         Other 13       Other 14         Other 38       Other 19         Other 19       Other 10         Other 12       Other 12         Other 37       Other 14         Other 19       Other 15         Other 10       Other 16         Other 12       Other 16         Other 12       Other 12         Other 20       Other 20         Other 21       Other 20	Other 32     Other 2       Other 3     Other 4       Other 3     Other 5       Other 34     Other 7       Other 35     Other 7       Other 36     Other 10       Other 12     Other 13       Other 37     Other 15       Other 18     Other 18       Other 18     Other 19       Other 19     Other 18       Other 19     Other 10	
Other 33       Other 5         Other 34       Other 6         Other 34       Other 7         Other 35       Other 7         Other 35       Other 10         Other 10       Other 11         Other 36       Other 13         Other 37       Other 15         Other 18       Other 18         Other 18       Other 12         Other 10       Other 15         Other 12       Other 16         Other 18       Other 20         Other 20       Other 21	Other 33       Other 5         Other 34       Other 6         Other 34       Other 7         Other 35       Other 7         Other 36       Other 10         Other 12       Other 13         Other 37       Other 16         Other 18       Other 18         Other 19       Other 18         Other 19       Other 19         Other 19       Other 19         Other 19       Other 19         Other 20       Other 10	
Other 34     Other 8       Other 35     Other 9       Other 10     Other 10       Other 12     Other 13       Other 37     Other 15       Other 18     Other 18       Other 19     Other 12       Other 20     Other 21       Other 22     Other 24	Other 34     Other 8       Other 35     Other 9       Other 10     Other 10       Other 13     Other 13       Other 37     Other 14       Other 15     Other 16       Other 17     Other 18       Other 19     Other 19       Other 19     Other 19       Other 19     Other 20	
Other 35     Other 10       Other 36     Other 11       Other 37     Other 13       Other 37     Other 15       Other 16       Other 18       Other 20       Other 21       Other 22	Other 35     Other 10       Other 13     Other 12       Other 37     Other 14       Other 37     Other 15       Other 18     Other 18       Other 19     Other 19       Other 20     Other 20	
Other 30         Other 13           Other 37         Other 15           Other 38         Other 16           Other 18         Other 18           Other 20         Other 21           Other 22         Other 24	Other 30         Other 13           Other 37         Other 15           Other 16         Other 16           Other 38         Other 17           Other 19         Other 19           Other 20         Other 20	
Other 37         Other 15           Other 38         Other 17           Other 18         Other 18           Other 20         Other 21           Other 22         Other 24	Other 37         Other 15           Other 16         Other 17           Other 18         Other 18           Other 19         Other 20	
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Other 21 Other 22		

	try System - S	Section B-13, Contr	act X0001, Pla	n 001, Seg	ment 000			<u> </u>		×
File Help		Exit	Exit (No	Go To:	#13h Additio	nal Services - Base 28		•	]	
Previous	Next	(Validate)	Validate)							
Indicate Copay	ment for one o	or more of the follow	ing services.							
			Minimum Copayment		imum ayment		Minimum Copayment	Maximum Copayment		
Early and Perio Treatment (EPS		, Diagnostic, and				Case Management				
Tobacco Cessa Women	tion Counseli	ng for Pregnant				Other 1				
Freestanding B	lirth Center Se	ervices				Other 2				
Respiratory Ca	re Services					Other 3				
Family Plannin	g Services					Other 4				
Nursing Home	Services					Other 5				
Home and Com	nmunity Based	d Services				Other 6				
Personal Care	Services					Other 7				
Self-Directed P	ersonal Assis	tance Services				Other 8				
Private Duty Nu	rsing Service	s				Other 9				
Case Managem	ient (Long Te	rm Care)				Other 10				
Institution for M Individuals 65 of		e Services for				Other 11				
	Intermediate C	Care Facility for				Other 12				
										11.

revious	Next	Exit (Validate)	Exit (No Validate)	Go To: #13	h Additional Services	- Base 29	•	
dicate Copa		more of the follow	ing services.					
	Minimum Copayment	Maximum Copayment			Minimum Copayment	Maximum Copayment		
ther 13				Other 26				
ther 14				Other 27				
ther 15				Other 28				
ther 16				Other 29				
ther 17				Other 30				
ther 18				Other 31				
ther 19				Other 32				
ther 20				Other 33				
ther 21				Other 34				
ther 22				Other 35				
ther 23				Other 36				
ther 24				Other 37				
ther 25				Other 38				



### #14a Medicare-covered Zero Dollar Preventive Services

🖳 PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segme File Help	nt 000		×
	14a Medicare-covered Zero Dollar Preventive Services		
CLICK FOR DESCRIPTION OF BENEFIT         Medicare-covered Zero Dollar Preventive Services Attestation         I attest that there is no coinsurance, copayment, or deductible for all         Original Medicare preventive services that are offered at zero dollar cost sharing.         Note: Plan may not require an authorization or referral for certain \$0 cost sharing preventive services, for example, screening mammograms.         Is authorization required?         ○ Yes         ○ No	Medicare-covered Zero Dollar Preventive Services Notes         Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.         Notes:		

# #14b Annual Physical Exam – Base 1

CLICK FOR DESCRIPTION OF BENEFIT Us should only use these supplemental benefits for Annual Physical as an accovered by Original Medicare. You may charge copays for ese Annual Physical Exams. NOTE: Medicare-covered preventive strices are always plan covered, and consequently they are not propriate as a supplemental benefit. See the plan provide the Annual Physical Exam as a supplemental benefit No Select type of benefit for the Annual Physical Exam: C Mandatory C Optional	vshould only use these supplemental benefits for Annual Physical isms not covered by Original Medicare.covered preventive vices are always plan covered, and consequently they are not propriate as a supplemental benefit.       C Yes         es the plan provide the Annual Physical Exam as a supplemental benefit der Part C?       Indicate Maximum Plan Benefit Coverage amount:         Yes       Indicate Maximum Enrollee Out-of-Pocket Cost?         Yes       No         Select type of benefit for the Annual Physical Exam:       Indicate Maximum Enrollee Out-of-Pocket Cost amount:         C Mandatory       Indicate Maximum Enrollee Out-of-Pocket Cost amount:	revious Next (Validate) Valid	(No	#14b Annual Physical Exam - Base 1	•	
		CLICK FOR DESCRIPTION OF BENEFIT CLICK FOR DESCRIPTION OF BENEFIT Dou should only use these supplemental benefits for An tams not covered by Original Medicare. You may char ese Annual Physical Exams. NOTE: Medicare-covere tryices are always plan covered, and consequently the propriate as a supplemental benefit. Des the plan provide the Annual Physical Exam as a s der Part C? Yes No Select type of benefit for the Annual Physical Exam C Mandatory	inual Physical rge copays for d preventive ey are not upplemental benefit	C Yes No Indicate Maximum Plan Benefit Coverage amount: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes C No		

# #14b Annual Physical Exam – Base 2

Help							
evious	Next	Exit (Validate)	Exit (No Validate)	Go To: 📕	4b Annual Physical Exam - Base 2	•	
here an enroll Yes No Indicate Mi Exam: Indicate Mi Exam: here an enrol Yes No	ollee Coinsurai Minimum Coins	Exit (Validate) Ince? Isurance percenta	Validate) age for each Anr	nual Physical	Is there an enrollee Copayment?		

# #14b Annual Physical Exam – Base 3

		4	¥	GelTer	#14b Annual Physical Exam - Base 3	•	1
evious	Next	Exit (Validate)	Exit (No Validate)	60 10.	j# 140 Annual Physical CAan - Dase 3		1
uthorization	required?						
Yes No							
	uired for the A	nnual Physical E	xam?				
Yes No							
e may inclu	al Exam Notes de additional i ot repeat infor	nformation to des mation captured in	cribe benefit in t n data entry.	his service			
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Previous Next (Validate) Validate)	Supplemental Benefits - Base 1	•
CLICK FOR DESCRIPTION OF BENEFIT           Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?           C Yes           C No   Select enhanced benefit (Select all that apply): Telemonitoring Services* Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotime)* Home and Bathroom Safety Devices and Modifications* Counseling Services In-Home Safety Assessment Personal Emergency Response System (PERS) Medical Nurthion Therapy (IMIT) Post discharge In-Home Medication Reconciliation Re-admission Prevention Wigs for Hair Loss Related to Chemotherapy Weight Management Programs* Atternative Therapies* Therapeutic Massage* Adult Day Heath Services* In-Bome Support Services* Support for Caregivers of Ennolees* * = A note is required when this benefit is offered.	Select type of benefit for Health Education:   Mandatory  Optional  Select type of benefit for Nutritional/Dietary Benefit:   Yes  Yes  Yes  Yes  No, indicate number Indicate number of visits for Nutritional/Dietary Benefit:  Indicate number of visits for Nutritional/Dietary Benefit:  Indicate setting for Nutritional/Dietary Benefit:  Indicate number of visits for Nutritional/Dietary Benefit:  Mandatory  Optional Indicate type of Finass Benefit offered in addition to Medicare:  Mandatory  Optional Indicate press Activity Tracker Select type of benefit for Enhanced Disease Management:  Mandatory  Optional	Select type of benefit for Telemonitoring Services:         \@ Mandatory         \@ Optional         Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):         \@ Mandatory         \@ Optional         Select type of Remote Access Technologies offered (Select all that apply):         \@ Web/Phone-based technologies         \@ Nursing Hotline         Select type of benefit for Home and Bathroom Safety Devices and Modifications:         \@ Mandatory         \@ Optional         Select type of benefit for Counseling Services:         \@ Mandatory         \@ Optional         Select type of benefit for Counseling Services:         \@ Mandatory         \@ Optional         Is this benefit unlimited for Counseling Services:         \@ No, indicate number         Indicate number of visits for Counseling Services:         \@ Indicate setting for Counseling Services:         \@ Indicate setting for Counseling Services:         \@ Indicate setting for Counseling Services:         \@ Indicate of Visits for Counseling Services:         \@ Indicate duration of sessions         \@ Group Sessions         \@ Both Sessions (Individual and Group)         Indicate duration of sessions (in minutes):

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File Help				
Previous Next (Validate)	Kana Kana Kana Kana Kana Kana Kana Kana	#14c Other Defined Supplemental Benefits - Base 2	•	
Previous     Next     (Validate)       Select type of benefit for Personal Emergency Res (PERS): <ul> <li>Mandatory</li> <li>Optional</li> <li>Select type of benefit for Medical Nutrition Therapy</li> <li>Mandatory</li> <li>Optional</li> </ul> Do you offer Additional Sessions for Medicare-cool <li>Yes</li> <li>No</li> <li>Indicate the limitfor Additional Sessions:</li> <li>Visits</li> <li>Hours</li> <li>Indicate numerical limit on the services provided Sessions:</li> <li>Yes</li> <li>No</li> <li>Indicate units a limit will be provided in for Coverage</li> <li>Yes</li> <li>No</li> <li>Indicate numerical limit on the services provided for Non-Medicare covered diseases:</li> <li>Visits</li> <li>Hours</li> <li>Indicate numerical limit on the services provided for Non-Medicare covered diseases:</li> <li>Select type of benefit for Post discharge In-Home Medication:</li> <li>C Mandatory</li> <li>Optional</li>	ponse System ((MNT): vered diseases? for Additional d diseases? in the notes field) rage for Non- d for Coverage	Select       we of benefit for Re-admission Prevention:         Optional         What does your Re-admission Prevention benefit include (check all that apply):         Meals         Medication Reconciliation         I-Home Safety Assessment         Other, Describe         Enter name of Service:         Please describe the Meal benefit included in Re-admission Prevention:         How many days does your Meal Benefit last?         What is the maximum number of meals the benefit provides?         Select type of benefit for Wigs for Hair Loss Related to Chemotherapy:         Mandatory         Optional         Select type of benefit for Weight Management Programs:         Mandatory         Optional         Select type of benefit for Alternative Therapies:         Mandatory         Optional         Select type of benefit for Alternative Therapies:         Mandatory         Optional         Is this benefit unlimited for Alternative Therapies?         Yes         No. indicate number         Indicate number of visits offered for Alternative Therapies?         Therapies:		
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File Help	Go To: #14c Other Defined Supplemental Benefits - Base 3	Ŧ	
Previous Next (Validate) Validate)			
Select type of benefit for Therapeutic Massage: C Mandatory	Select type of benefit for Adult Day Health Services:		
C Optional	C Optional		
Is this benefit unlimited?			
C Yes C No	Select type of benefit for Home-Based Palliative Care:		
Indicate limit for number of sessions	C Mandatory C Optional		
Indicate the number of sessions periodicity:	Select type of benefit for In-Home Support Services:		
<ul> <li>○ Every three years</li> <li>○ Every two years</li> <li>○ Every year</li> </ul>	C Mandatory C Optional		
C Every six months C Every three months			
C Other, Describe	Select type of benefit for Support for Caregivers of Enrollees:		
	C Mandatory C Optional		
	Select the type of benefit offered:		
	Caregiver Training		
	Other description:		

Previous Next (Validate)	Go To: #14c Other Defined Supplemental Benefits - Base 4	•
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits? C Yes No Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that appl Health Education Nutritiona/Dietary Benefit Additional Sessions of Smoking and Tobacco Cessation Counse Finess Benefit Enhanced Disease Management Telemonitoring Services Remote Access Technologies (including Web/Phone-based tech Home and Bathroom Safety Devices and Modifications Counseling Services In-Home Safety Assessment Personal Emergency Response System (PERS) Medical Nutrition Therapy (MNT) Post discharge In-Home Medication Reconciliation Re-admission Prevention Wight Management Programs Alternative Therapies	C Every year C Every six months C Every three months C Other, Describe Indicate Maximum Plan Benefit Coverage amount for Nutritional/Dietary Benefit:	Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit: Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit: Every three years Every three years Every six months Every three months Monthly Other, Describe Indicate Maximum Plan Benefit Coverage amount for Enhance Disease Management: Every three years Every two years Every six months Every six months Other, Describe Indicate Maximum Plan Benefit Coverage amount for Telemonitoring Services: Select Maximum Plan Benefit Coverage amount for Telemonitoring Services: Select Maximum Plan Benefit Coverage amount for Telemonitoring Services: Every three years Every three months Other, Describe

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #14c Other Defined Supplemental Benefits - Base 5	<b>•</b>
Access Techno and Nursing Ho Select Maximur Access Techno Access Techno C Every three C Every three C Every year C Every six m C Every six m	Plan Benefit m Plan Benefit ologies (includ ottine): e years years e months e months cribe num Plan Benefit	t Coverage period ding Web/Phone-b	as ed technologies	Indicate Maximum Plan Benefit Coverage amount for In-Home Safety Assessment: Select Maximum Plan Benefit Coverage periodicity for In-Home Safety Assessment: C Every three years C Every two years C Every two years C Every year C Every year C Every six months C Other, Describe Indicate Maximum Plan Benefit Coverage amount for Personal Emergency Response System (PERS): Select Maximum Plan Benefit Coverage periodicity for Personal	Indicate Maximum Plan Benefit Coverage amount for Post dischargeIn-Home Medication Reconciliation: Select Maximum Plan Benefit Coverage periodicity for Post discharge In-Home Medication Reconciliation: Every three years Every two years Every year Every year Every six months Every three months Other, Describe Indicate Maximum Plan Benefit Coverage amount for Re- admission Prevention:
	ty Devices an e years years	t Coverage perioc d Modifications:	licity for Home and	Emergency Response System (PERS): C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	Select Maximum Plan Benefit Coverage periodicity for Re- admission Prevention: C Every three years C Every two years C Every year C Every six months C Every three months
Services:	cribe num Plan Bene	-	unt for Counseling	Indicate Maximum Plan Benefit Coverage amount for Medical Nutrition Therapy (MNT): Select Maximum Plan Benefit Coverage periodicity for Medical Nutrition Therapy (MNT):	C Other, Describe Indicate Maximum Plan Benefit Coverage amount for Wigs fo Hair Loss Related to Chemotherapy: Select Maximum Plan Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:
Select Maximu Counseling Se Every three Every two y Every year Every six n Every six n Every three Other. Des	ervices: e years years nonths e months	t Coverage period	licity for	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every three years Every two years Every two years Every six months Every three months Other, Describe

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File Help		
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Indicate Maximum Plan Benefit Coverage amount for Weight Management Programs: Select Maximum Plan Benefit Coverage periodicity for Weight Management Programs: Every three years Every three years Every yoy year Every year Every six months Every three months Other, Describe Indicate Maximum Plan Benefit Coverage amount for Alternative Therapies:	Indicate Maximum Plan Benefit Coverage amount for Adult Day Health Services: Select Maximum Plan Benefit Coverage periodicity for Adult Day Health Services: Every three years Every two years Every two years Every year Every six months Every three months Other, Describe Indicate Maximum Plan Benefit Coverage amount for Home- Based Palliative Care:	Indicate Maximum Plan Benefit Coverage amount for Support for Caregivers of Enrollees: Select Maximum Plan Benefit Coverage periodicity for Support for Caregivers of Enrollees: © Every three years © Every two years © Every two years © Every six months © Every six months © Every three months © Other, Describe
Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies: C Every three years C Every two years C Every year C Every year C Every six months C Every three months	Select Maximum Plan Benefit Coverage periodicity for Home- Based Palliative Care: C Every three years C Every two years C Every year C Every year C Every six months C Every three months	
O Other, Describe	O Other, Describe	
Indicate Maximum Plan Benefit Coverage amount for Therapeutic Massage: Select Maximum Plan Benefit Coverage periodicity for Therapeutic Massage:	Indicate Maximum Plan Benefit Coverage amount for In-Home Support Services: Select Maximum Plan Benefit Coverage periodicity for In-Home Support Services:	
C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	

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Is there a service-specific Maximum Enrollee Out-of-Pocket Cost Indicate Maximum Enrollee Out-of-Pocket Cost amount for Additional Indicate Maximum Enrollee Out-of-Pocket Cost amount for Remote	Access Tech	nologies
for Other Defined Supplemental Benefits? Sessions of Smoking and Tobacco Cessation Counseling: (including Web/Phone-based technologies and Nursing Hotline):		
C res C No Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Additional Sessions of Smoking and Tobacco Cessation Counseling: Technologies (including Web/Phone-based technologies and Nur		;
Select which Other Defined Supplemental Benefits have a Maximum Enrollee Out-of-Pocket Cost (Select all that apply): C Every three years C Every three years		7
Health Education C Every two years C Every two years		
Nutritional/Dietary Benefit C Every year C Every year		
Additional Sessions of Smoking and Tobarco Cessation Counsel C Every six months		
Fitness Benefit C Every three months C Every three months		
Enhanced Usease Management         C Other, Describe         C Other, Describe           Telemont/ong Services         C Other, Describe         C Other, Describe		
Remote Access Technologies (including Web/Phone-based tech Home and Bathroom Safety Devices and Modifications Counseling Services	nd	
In-Home Safety Assessment In-Home Safety Assessment Personal Emergency Response System (PERS) Medical Nutrition Therapy (IMNT) Entress Benefit: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Fitness Benefit: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Select the Maximum Enrollee Out-of-Pocket Cost periodicity	me	
Post discharge in-Home Medication Reconciliation C Every three years C Every three years		
Re-admission Prevention		
Wigs for Hair Loss Related to Chemotherapy		
Weight Management Programs Atternative Therapies V C Every six months C Every six months		
O Every three months		
Indicate Maximum Enrollee Out-of-Pocket Cost amount for C Other, Describe C Other, Describe C Other, Describe		
Indicate Maximum Enrollee Out-of-Pocket Cost amount for Enhanced Disease Management:		
Select the Maximum Enrollee Out-of-Pocket Cost periodicity for		
Health Education:         Select the Maximum Enrollee Out-of-Pocket Cost periodicity for         Select the Maximum Enrollee Out-of-Pocket Cost periodicity for           C Every three years         Enhanced Disease Management:         Select the Maximum Enrollee Out-of-Pocket Cost periodicity for		
C Every two years C Every three years C Every three years		
C Every two years		
C Every six months C Every year C Every year		
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Indicate Maximum Enrollee Out-of-Pocket Cost amount for C Other, Describe C Other, Describe		
Indicate Maximum Enrollee Out-of-Pocket Cost amount for Telemonitoring Services: Safety Assessment:	e	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Nutritional/Dietary Benefit: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Select the Maximum Enrollee Out-of-Pocket Cost periodicity for In-		
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Indicate Maximum Enrollee Out-of-Pocket Cost amount for Personal Emergency Response System (PERS): Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Personal Emergency Response System (PERS): Every three years Every two years Every two years Every year Every year Every six months Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medical Nutrition Therapy (MNT):	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Re- admission Prevention: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Re-admission Prevention: Every three years Every three years Every year Every six months Every six months Every six months Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Wigs for Hair Loss Related to Chemotherapy:	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Alternative Therapies: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Alternative Therapies: C Every three years C Every two years C Every year C Every year C Every year C Every six months C Every three months C Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Therapeutic Massage:
Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medical Nutrition Therapy (MNT):	Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Wigs for Hair Loss Related to Chemotherapy:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Therapeutic Massage:
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Indicate Maximum Enrollee Out-of-Pocket Cost amount for Post discharge In-Home Medication Reconciliation: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Post discharge In-Home Medication Reconciliation:	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Weight Management Programs: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Weight Management Programs:	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Adult Day Health Services: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Adult Day Health Services:
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dicate Maximum Enrollee Out-of-Pocket Cost am me Support Services:							
lect the Maximum Enrollee Out-of-Pocket Cost p r In-Home Support Services:	periodicity						
r In-Home Support Services:	periodicity						
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r In-Home Support Services: Every three years Every two years Every year Every six months Every three months Other, Describe dicate Maximum Enrollee Out-of-Pocket Cost an	mount for						
r In-Home Support Services: Every three years Every two years Every year Every six months Every three months Other, Describe dicate Maximum Enrollee Out-of-Pocket Cost an ipport for Caregivers of Enrollees: elect the Maximum Enrollee Out-of-Pocket Cost p r Support for Caregivers of Enrollees: Every three years	mount for						
r In-Home Support Services: Every three years Every two years Every year Every six months Every three months Other, Describe dicate Maximum Enrollee Out-of-Pocket Cost an upport for Caregivers of Enrollees: elect the Maximum Enrollee Out-of-Pocket Cost pro- support for Caregivers of Enrollees: Every three years Every three years	mount for						
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	To:  ≢14c Other Defined Supplemental Benefits - Base 10		
Is there an enrollee Coinsurance?   Yes No Select which Other Defined Supplemental Benefits have a Coinsurance (Select all that apply): Heath Education Nutritional/Detary Benefit Additional/Detary Benefit Enhanced Disease Management Telemonitoring Services Remote Access Technologies (including Web/Phone-based techr Home and Bathroom Safety Devices and Modifications Counseling Services In-Home Safety Assessment Personal Emergency Response System (PERS) Medical Nutrition Therapy (MNT)	Indicate Minimum Coinsurance percentage for Fitness Benefit: Indicate Maximum Coinsurance percentage for Fitness Benefit: Indicate Minimum Coinsurance percentage for Enhanced Disease Management: Indicate Maximum Coinsurance percentage for Enhanced Disease Management: Indicate Minimum Coinsurance percentage for Telemonitoring Services:	Indicate Minimum Coinsurance percentage for Counseling Services: Indicate Maximum Coinsurance percentage for Counseling Services: Indicate Minimum Coinsurance percentage for In-Home Safety Assessment: Indicate Maximum Coinsurance percentage for In-Home Safety Assessment: Indicate Minimum Coinsurance percentage for Personal Emergency Response System (PERS):	Indicate Minimum Coinsurance percentage for Wigs for Hair Loss Related to Chemotherapy: Indicate Maximum Coinsurance percentage for Wigs for Hair Loss Related to Chemotherapy: Indicate Minimum Coinsurance percentage for Weight Management Programs: Indicate Maximum Coinsurance percentage for Weight Management Programs: Indicate Minimum Coinsurance percentage for Alternative Therapies: Indicate Minimum Coinsurance percentage for Alternative Therapies:
Post discharge In-Home Medication Reconciliation Re-admission Prevention Wigs for Hair Loss Related to Chemotherapy Indicate Minimum Coinsurance percentage for Health Education:	Indicate Maximum Coinsurance percentage for Telemonitoring Services: Indicate Minimum Coinsurance percentage for Remote Access Technologies (Web/Phone-based technologies):	Indicate Maximum Coinsurance percentage for Personal Emergency Response System (PERS): Indicate Minimum Coinsurance percentage for Medical Nutrition Therapy (MNT):	Indicate Maximum Coinsurance percentage for Alternative Therapies: Indicate Minimum Coinsurance percentage for Therapeutic Massage:
Indicate Maximum Coinsurance percentage for Health Education:	Indicate Maximum Coinsurance percentage for Remote Access Technologies (Web/Phone-based technologies):	Indicate Maximum Coinsurance percentage for Medical Nutrition Therapy (MNT):	Indicate Maximum Coinsurance percentage for Therapeutic Massage:
Indicate Minimum Coinsurance percentage for Nutritional/Dietary Benefit:	Indicate Minimum Coinsurance percentage for Remote Access Technologies (Nursing Hotline):	Indicate Minimum Coinsurance percentage for Post discharge In-Home Medication Reconciliation:	Indicate Minimum Coinsurance percentage for Adult Day Health Services:
Indicate Maximum Coinsurance percentage for Nutritional/Dietary Benefit: Indicate Minimum Coinsurance percentage for Additional Sessions	Indicate Maximum Coinsurance percentage for Remote Access Technologies (Nursing Hotline):	Indicate Maximum Coinsurance percentage for Post discharge In-Home Medication Reconciliation:	Indicate Maximum Coinsurance percentage for Adult Day Health Services:
of Smoking and Tobacco Cessation Counseling: Indicate Maximum Coinsurance percentage for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Indicate Minimum Coinsurance percentage for Home and Bathroom Safety Devices and Modifications: Indicate Maximum Coinsurance percentage for Home and Bathroom Safety Devices and Modifications:	Indicate Minimum Coinsurance percentage for Re-admission Prevention: Indicate Maximum Coinsurance percentage for Re-admission Prevention:	

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Is there an enrollee Deductible?	Indicate Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Indicate Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications:	Indicate Minimum Copayment amount for Re-admission Prevention:
Indicate Deductible Amount:	Indicate Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Indicate Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications:	Indicate Maximum Copayment amount for Re-admission Prevention:
Is there an enrollee Copayment?	Indicate Minimum Copayment amount for Fitness Benefit:	Indicate Minimum Copayment amount for Counseling Services:	Indicate Minimum Copayment amount for Wigs for Hair Loss Related to Chemotherapy:
Select which Other Defined Supplemental Benefits have a Copayment (Select all that apply):	Indicate Maximum Copayment amount for Fitness Benefit:	Indicate Maximum Copayment amount for Counseling Services;	Indicate Maximum Copayment amount for Wigs for Hair Loss Related to Chemotherapy:
Nutritiona/Dietary Benefit Additional Sessions of Smoking and Tobacco Cessation Counsel Fitness Benefit Enhanced Disease Management	Indicate Minimum Copayment amount for Enhanced Disease Management:	Indicate Minimum Copayment amount for In-Home Safety Assessment:	Indicate Minimum Copayment amount for Weight Management Programs:
Telemonitoring Services Remote Access Technologies (including Web/Phone-based techn Home and Bathroom Safety Devices and Modifications Counseling Services	Indicate Maximum Copayment amount for Enhanced Disease Management:	Indicate Maximum Copayment amount for In-Home Safety Assessment:	Indicate Maximum Copayment amount for Weight Management Programs:
In-Home Safety Assessment Personal Emergency Response System (PERS) Medical Nutrition Therapy (IINT) Post discharge In-Home Medication Reconciliation	Indicate Minimum Copayment amount for Telemonitoring Services:	Indicate Minimum Copayment amount for Personal Emergency Response System (PERS):	Indicate Minimum Copayment amount for Alternative Therapies:
Re-admission Prevention Wigs for Hair Loss Related to Chemotherapy Weight Management Programs Alternative Therapies	Indicate Maximum Copayment amount for Telemonitoring Services:	Indicate Maximum Copayment amount for Personal Emergency Response System (PERS):	Indicate Maximum Copayment amount for Alternative Therapies:
Indicate Minimum Copayment amount for Health Education:	Indicate Minimum Copayment amount for Remote Access Technologies (Web/Phone-based technologies):	Indicate Minimum Copayment amount for Medical Nutrition Therapy (MNT):	Indicate Minimum Copayment amount for Therapeutic Massage:
Indicate Maximum Copayment amount for Health Education:	Indicate Maximum Copayment amount for Remote Access Technologies (Web/Phone-based technologies):	Indicate Maximum Copayment amount for Medical Nutrition Therapy (MNT):	Indicate Maximum Copayment amount for Therapeutic Massage:
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	Indicate Minimum Copayment amount for Remote Access Technologies (Nursing Hotline):	Indicate Minimum Copayment amount for Post discharge In-Home Medication Reconcillation:	Indicate Minimum Copayment amount for Adult Day Health Services:
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit	Indicate Maximum Copayment amount for Remote Access Technologies (Nursing Hotline):	Indicate Maximum Copayment amount for Post discharge In-Home Medication Reconciliation:	Indicate Maximum Copayment amount for Adult Day Health Services:

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ndicate Maxi Care:	mum Copayn	ent amount for Ho	me-Based Palli	ative			
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ervices:		ent amount for m-r	tome Support				
ndicate Maxi Services:	mum Copaym	ient amount for In-I	Home Support				
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ndicate Maxi	mum Copaym	ient amount for Sup	oport for Careq	ivers			
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ls authorizatior	n required?					Additional Sessions of Smoking and Tobacco Cessation Counseling N	otes:	
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Is a referral req	uired for Othe	er Defined Supple	mental Benefits	?				
O Yes O No							~	
Other Defined	Supplemental	Benefits Notes:				, Fitness Benefit Notes:*	<b>A</b>	
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*=This notes f	ield is required	d when the corres	oonding benefi	tis offered.				
Health Educati	on Notes:					 Enhanced Disease Management Notes:	~	
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, Home and Bathroom Safety Devices and Modifications Notes:*	Medical Nutrition Therapy (MNT) Notes:		
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Counseling Services Notes:	Post discharge In-Home Medication Reconciliation Notes:		
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#### #14d Kidney Disease Education Services Base 1

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CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Ca Maximum Plan Benefit Coverage is not applicable for the Is there a service-specific Maximum Enrollee Out-of-Po C Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amound Select the Maximum Enrollee Out-of-Pocket Cost per C Every two years C Every two years C Every two years C Every two years C Every three months O Other, Describe	is Service Category. Incket Cost?	You must include total cost sharing to the beneficiary, including any facility cost sharing, if you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.         Is there an enrollee Coinsurance?            Yes             No          Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:          Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:		

#### #14d Kidney Disease Education Services Base 2

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Is there an enr	ollee Deducti	ble?			Is authorization required?			
C Yes C No					C Yes C No			
Indicate De	ductible Amou	unt:			Is a referral required for Kidney Disease Education Services?			
Is there an enr	ollee Copaym	ient?			C Yes C No			
C Yes C No								
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Indicate Ma	ximum Copav	ment amount for M	Medicare-cover	ed				
Benefits:								
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### #14d Kidney Disease Education Services – Base 3

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idney Diseas	e Education S	ervices Notes						
ote may inclu	de additional i	nformation to des	cribe benefit in t	this service	category. Do not repeat information captured in data entry.			
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CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category. Glaucoma screening, diabetes self-management training, barium enemas, digital rectal exams, EKG following welcome visit, and Other Medicare-covered preventive services are Medicare-covered preventive services for which data entry must be completed in this	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare- covered Glaucoma Screening: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Glaucoma Screening: C Every three years C Every three years C Every year C Every year	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare- covered Digital Rectal Exams: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Digital Rectal Exams: C Every three years C Every three years C Every two years C Every year C Every six months
section. See the Benefit Description for more guidance. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services? C Yes C Yes	C Every three months C Other, Describe	C Every three months C Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare- covered EKG following Welcome Visit:
C No Select which Services have a Maximum Enrollee Out-of-Pocket Cost (Select all that apply): Medicare-covered Glaucoma Screening Medicare-covered Diabetes Self-Management Training Medicare-covered Barium Enemas Medicare-covered Digital Rectal Exams Medicare-covered EKG following Welcome Visit	Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Diabetes Self-Management Training: C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Other. Describe	Select the Enrollee Out-of-Pocket Cost periodicity for Medicare- covered EKG following Welcome Visit: C Every three years C Every two years C Every year C Every six months C Every three months C Other. Describe
	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare- covered Barium Enemas:  Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Barium Enemas:  Every three years Every three years Every two years Every six months Every three months Cother. Describe	

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Is there an enrollee Coinsural	nce?			Is there an enrollee Deductible?	1		
<ul> <li>○ No</li> <li>Select which Services hav</li> <li>○ Medicare-covered Glau</li> <li>○ Medicare-covered Diab</li> <li>○ Medicare-covered Barii</li> <li>○ Medicare-covered Digi</li> <li>○ Medicare-covered EKG</li> </ul>	ucoma Screening betes Self-Manag um Enemas tal Rectal Exams	g jement Training	pply):	No     Select which Services have a Deductible (Select all that apply):     Medicare-covered Glaucoma Screening     Medicare-covered Diabetes Self-Management Training     Medicare-covered Barium Enemas     Medicare-covered Digital Rectal Exams     Medicare-covered EKG following Welcome Visit     Indicate Medicare-covered Glaucoma Screening Deductible Amount:			
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Diabetes Self- Management Training Medicare-covered Barium Enemas				Indicate Medicare-covered Barium Enemas Deductible Amount:			
Medicare-covered Digital Rectal Exams				Indicate Medicare-covered Digital Rectal Exams Deductible Amount:			
Medicare-covered EKG following Welcome Visit				Indicate Medicare-covered EKG following Welcome Visit Deductible Amount:			

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there an enrollee Copayme	ent?		1	s authorization required for Medicare-covered Glaucoma Screening?		
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Medicare-covered Diat		gement Training		C Yes C No		
Medicare-covered Digi Medicare-covered EKG				s authorization required for Medicare-covered Barium Enemas?		
	Minimum Copayment	Maximum Copayment		C Yes C No		
Medicare-covered Glaucoma Screening				s authorization required for Medicare-covered Digital Rectal Exams?		
Medicare-covered Diabetes Self- Management Training				C Yes C No		
Medicare-covered Barium Enemas				s authorization required for Medicare-covered EKG following Welcome Visit?		
Medicare-covered Digital Rectal Exams				C Yes C No		
Medicare-covered EKG following Welcome Visit						

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Medicare-covered Gl	aucoma Screening Note	ec.		Medicare-covered Digital Rectal Exams Notes:			
	acconta concerning river		~			$\sim$	
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Medicare covered Di	abetes Self-Managemer	t Training Notes:		Medicare-covered EKG following Welcome Visit Notes:			
	aberes cen-managemen	it framing totos.	~			$\wedge$	
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### #15 Medicare Part B Rx Drugs – Base 1

🖷 PBP Data Entry System - Section B-15, Contract X0001, Plan File Help	001, Segment 000	_	×
Previous Next (Validate) Exit (No Validate)	Go To: #15 Medicare Part B Rx Drugs - Base 1	<b>_</b>	
CLICK FOR DESCRIPTION OF BENEFIT         Is there a Maximum Enrollee Out-of-Pocket Cost?         No         Indicate Maximum Enrollee Out-of-Pocket Cost Amount:         Select the Maximum Enrollee Out-of-Pocket Cost periodicity:         Every three years         Every three years         Every two years         Every six months         Every three months         Every month         Other, Describe	Is there an enrollee Coinsurance?		

#### #15 Medicare Part B Rx Drugs – Base 2

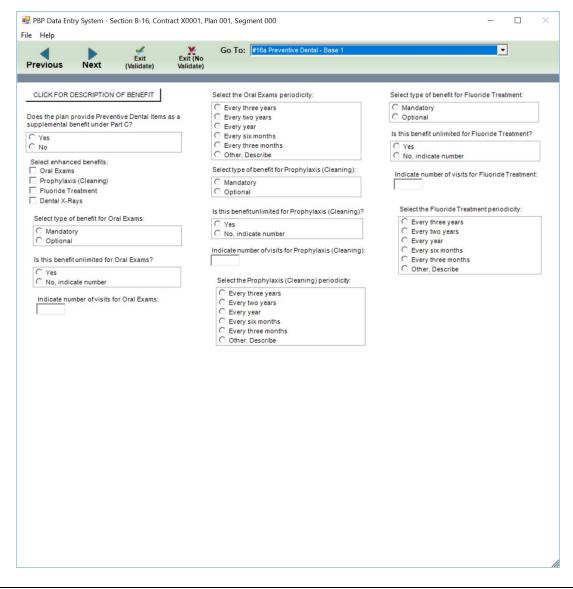
revious Next (Validate) Go To	p: #15 Medicare Part B Rx Drugs - Base 2	
there an enrollee Copayment?	Is there an enrollee Deductible?	
Yes	C Yes C No	
Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply): Medicare Part B Chemotherapy/Radiation Drugs Other Medicare Part B Drugs	Indicate Deductible Amount:	
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	O Yes O No	
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	Does the plan offer step therapy? C Yes C No	
Indicate Minimum Copayment Amount for other Medicare Part B Drugs:	Does the benefit step from (select all that apply):	
Indicate Maximum Copayment Amount for other Medicare Part B Drugs:	Part B to Part D? Part D to Part B?	

#### #15 Medicare Part B Rx Drugs – Notes

revious	Next	Exit (Validate)	Exit (No Validate)							
edicare Part	3 Rx Drugs No	otes								
		nformation to des	cribe benefit in t	this service	ategory Do p	trepeatinformat	tion cantured i	n data entry		
		this Service Categ			alogoi, boin		i en euptereur	in dulu on in j.		
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#### #15 Home Infusion Bundled Services

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ile Help				
Previous Next (Validate	Exit (No	#15 Home Infusion Bundled Services	-	
Does the plan provide Part D home infusio as a mandatory supplemental benefit? Yes No If you select 'Yes' to 'Does the plan provide of a bundled service as a supplemental be specific medications in a flat file which mus Submission Module by Friday, June 5, 202 You must also ensure that your benefit incl but any services and supplies associated the administration. If your organization elects to provide Part supplemental bundled service then those sharing. As described in the CY 2010 Call the application of zero cost sharing for the provided under a supplemental benefit.	de Part D home infusion drugs as p benefit?', you must indicate these ust be uploaded through the Formu 220 at 11:59 am Eastern Time. cludes not only the home infusion i with the home infusion drug's t D home infusion drugs as part of e services must be provided at S0 c I Letter this waiver is conditioned c	Medicaid benefit?		



📲 PBP Data Entry System - Section B-16, Con File Help	tract X0001, Plan 001, Segment 000	_	- C	
Previous Next (Validate)	Y Go To: ≢16a Preventive Dental - Base 2 Exit No Validate)		•	
Select type of benefit for Dental X-Rays: C Mandatory C Optional Is this benefit unlimited for Dental X-Rays? C Yes No, indicate number Indicate number of visits for Dental X-Rays:	Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes C No Does the Maximum Plan Benefit Coverage amount apply to In- network services only OR does it apply to both In-network and Out- of-network services? C In-network services? C Both In-network and Out-of-network services			
Select the Dental X-Rays periodicity: C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Other, Describe	Indicate Maximum Plan Benefit Coverage amount: Select the Maximum Plan Benefit Coverage periodicity: C Every three years C Every thro years C Every year C Every six months C Every three months			
	C Other, Describe			

Previous Next (Validate) Go	To: #16a Preventive Dental - Base 3	<b></b>
s there a service-specific Maximum Enrollee Out-of-Pocket Cost?          Yes         Indicate Maximum Enrollee Out-of-Pocket Cost amount:         Select the Maximum Enrollee Out-of-Pocket Cost periodicity:         Every three years         Every three years         Every three years         Every three months         Other, Describe         Is there an enrollee Coinsurance?         Yes         No         Select which Preventive Dental Services have a Coinsurance (Select all that apply):         Oral Exams         Prophylaxis (Cleaning)         Fluoride Treatment         Dental X-Rays	Is there a combination of services included in a single cost per Office Visit?           Yes         No         Select which combination of services are included in a single cost per Office Visit:         Oral Exams         Prophylaxis (Cleaning)         Fluoride Treatment         Dental X-Rays    Indicate Minimum Coinsurance percentage for Office Visits:          Indicate Maximum Coinsurance percentage for Office Visits:         Indicate Maximum Coinsurance percentage for Office Visits:         Indicate Maximum Coinsurance percentage for Office Visits:         Indicate Maximum Coinsurance percentage for Office Visits:	Indicate Minimum Coinsurance percentage i Prophylaxis (Cleaning): Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning): Indicate Minimum Coinsurance percentage i fuoride Treatment: Indicate Maximum Coinsurance percentage i Indicate Minimum Coinsurance percentage i Indicate Minimum Coinsurance percentage i Indicate Maximum Coinsurance percentage i Ind

there an enrollee Deductible?       Indicate Minimum Copayment amount for Office Visit:         Indicate Maximum Copayment amount for Office Visit:       Indicate Minimum Copayment amount for Office Visit:         Indicate Minimum Copayment amount for Office Visit:       Indicate Minimum Copayment amount for Office Visit:         Indicate Minimum Copayment amount for Office Visit:       Indicate Minimum Copayment amount for Office Visit:         Setext which Preventive Dental Services have a Copayment       Indicate Minimum Copayment amount for Office Visit:         Office Visit:       Indicate Minimum Copayment amount for Prophylaxis (Cleaning):         Prophylaxis (Cleaning)       Indicate Minimum Copayment amount for Prophylaxis (Cleaning):         Prophylaxis (Cleaning)       Indicate Minimum Copayment amount for Fluoride Treatment:         Office Visit:       Indicate Minimum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Minimum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Minimum Copayment amount for Dental X-Rays:         Oral Exams       Indicate Maximum Copayment amount for Dental X-Rays:       Indicate Maximum Copayment amount for Dental X-Rays:         Oral Exams       Indicate Maximum Copayment amount for Dental X-Rays:       Indicate Maximum Copayment amount for Dental X-Rays:	revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	#16a Preventive Dental - Base 4	•	]	
No       Indicate Maximum Copayment amount for Office Visit:         Indicate Deductible Amount:       Indicate Maximum Copayment amount for Oral Exams:         Indicate Minimum Copayment amount for Oral Exams:       Indicate Maximum Copayment amount for Oral Exams:         Yes       Indicate Maximum Copayment amount for Oral Exams:         Select which Preventive Dental Services have a Copayment       Indicate Minimum Copayment amount for Prophylaxis (Cleaning):         Oral Exams       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Fluoride Treatment:         Office Visit?       Indicate Maximum Copayment amount for Fluoride Treatment:         Office Visit?       Indicate Maximum Copayment amount for Fluoride Treatment:         Office Visit?       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Maximum Copayment amount for Dental X-Rays:         Oral Exams       Indicate Maximum Copayment amount for Dental X-Rays:       Indicate Minimum Copayment amount for Dental X-Rays:         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Dental X-Rays:       Indicate Maximum Copayment amount for Dental X-Rays:	there an enro	ollee Deductib	de?			Indicate Minimum Copayment amount for Office Visit:			
Indicate Deductible Amount:       Indicate Maximum Copayment amount for Office Visit:         Indicate Deductible Amount:       Indicate Maximum Copayment amount for Oral Exams:         Indicate Maximum Copayment amount for Oral Exams:       Indicate Maximum Copayment amount for Oral Exams:         Yes       Indicate Maximum Copayment amount for Oral Exams:         No       Indicate Maximum Copayment amount for Oral Exams:         Select which Preventive Dental Services have a Copayment       Indicate Minimum Copayment amount for Prophylaxis (Cleaning):         Oral Exams       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Is there a combination of services included in a single cost per Office Visit?       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Maximum Copayment amount for Fluoride Treatment:         Or a Exams       Indicate Maximum Copayment amount for Pluoride Treatment:         Select which combination of services are included in a single       Indicate Maximum Copayment amount for Dental X-Rays:         Or a Exams       Indicate Minimum Copayment amount for Dental X-Rays:         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Dental X-Rays:	Yes								
Indicate Deductible Amount:       Indicate Minimum Copayment amount for Oral Exams:         Indicate Minimum Copayment amount for Oral Exams:       Indicate Maximum Copayment amount for Oral Exams:         Yes       Indicate Maximum Copayment amount for Oral Exams:         No       Indicate Minimum Copayment amount for Oral Exams:         Select which Preventive Dental Services have a Copayment       Indicate Minimum Copayment amount for Prophylaxis (Cleaning):         Oral Exams       Indicate Minimum Copayment amount for Prophylaxis (Cleaning):         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Fluoride Treatment       Indicate Minimum Copayment amount for Fluoride Treatment:         Office Visit?       Indicate Maximum Copayment amount for Fluoride Treatment:         Office Visit?       Indicate Maximum Copayment amount for Fluoride Treatment:         Office Visit?       Indicate Maximum Copayment amount for Fluoride Treatment:         Office Visit?       Indicate Maximum Copayment amount for Dental X-Rays:         Oral Exams       Indicate Maximum Copayment amount for Dental X-Rays:         Prophylaxis (Cleaning)       Indicate Minimum Copayment amount for Dental X-Rays:	No					Indicate Maximum Consument amount for Office Visit			
there an enrollee Copayment?       Indicate Maximum Copayment amount for Oral Exams:         Yes       Indicate Maximum Copayment amount for Oral Exams:         Select which Preventive Dental Services have a Copayment (Select all that apply):       Indicate Minimum Copayment amount for Prophylaxis (Cleaning):         Oral Exams       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Is there a combination of services included in a single cost per Office Visit?       Indicate Minimum Copayment amount for Fluoride Treatment:         Yes       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit?       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Maximum Copayment amount for Dental X-Rays:         Oral Exams       Indicate Minimum Copayment amount for Dental X-Rays:         Prophylaxis (Cleaning)       Indicate Minimum Copayment amount for Dental X-Rays:	Indicate De	ductible Amo	unt:						
Yes       Indicate Maximum Copayment amount for Oral Exams:         No       Indicate Maximum Copayment amount for Oral Exams:         Select which Preventive Dental Services have a Copayment       Indicate Minimum Copayment amount for Prophylaxis (Cleaning):         Oral Exams       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Indicate Maximum Copayment amount for Prophylaxis (Cleaning):       Indicate Maximum Copayment amount for Fluoride Treatment:         Office Visit?       Indicate Maximum Copayment amount for Fluoride Treatment:         Yes       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit?       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Maximum Copayment amount for Putal X-Rays:         Prophylaxis (Cleaning)       Indicate Minimum Copayment amount for Dental X-Rays:         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Dental X-Rays:	1					Indicate Minimum Copayment amount for Oral Exams:			
No       Indicate Minimum Copayment amount for Prophylaxis (Cleaning):         Select which Preventive Dental Services have a Copayment       Indicate Minimum Copayment amount for Prophylaxis (Cleaning):         Oral Exams       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Indicate Maximum Copayment amount for Prophylaxis (Cleaning):       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Maximum Copayment amount for Pluoride Treatment:         Or al Exams       Indicate Minimum Copayment amount for Dental X-Rays:         Prophylaxis (Cleaning)       Fluoride Treatment	there an enro	ollee Copaym	ent?						
Select which Preventive Dental Services have a Copayment (Select all that apply):       Indicate Minimum Copayment amount for Prophylaxis (Cleaning):         Oral Exams       Indicate Minimum Copayment amount for Prophylaxis (Cleaning):         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Indicate Maximum Copayment amount for Prophylaxis (Cleaning):       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Is there a combination of services included in a single cost per Office Visit?       Indicate Minimum Copayment amount for Fluoride Treatment:         Yes       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Minimum Copayment amount for Dental X-Rays:         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Dental X-Rays:         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Dental X-Rays:					1	Indicate Maximum Copayment amount for Oral Exams:			
Select which combination of services are included in a single cost per Office Visit:       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Oral Exams       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Is there a combination of services included in a single cost per Office Visit?       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Maximum Copayment amount for Fluoride Treatment:         Oral Exams       Indicate Minimum Copayment amount for Dental X-Rays:         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Dental X-Rays:	No								
Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Dental X-Rays       Indicate Maximum Copayment amount for Prophylaxis (Cleaning):         Is there a combination of services included in a single cost per       Indicate Minimum Copayment amount for Fluoride Treatment:         Office Visit?       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Minimum Copayment amount for Dental X-Rays:         Oral Exams       Indicate Minimum Copayment amount for Dental X-Rays:         Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Dental X-Rays:			ental Services hav	ve a Copayment		Indicate Minimum Copaymentamount for Prophylaxis (Cleaning):			
Fluoride Treatment       Indicate Maximum Copayment amount for Prophysixis (Cleaning):         Dental X-Rays       Indicate Maximum Copayment amount for Prophysixis (Cleaning):         Is there a combination of services included in a single cost per Office Visit?       Indicate Minimum Copayment amount for Fluoride Treatment:         Yes       Indicate Maximum Copayment amount for Fluoride Treatment:       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Minimum Copayment amount for Dental X-Rays:         Prophylaxis (Cleaning)       Fluoride Treatment       Indicate Maximum Copayment amount for Dental X-Rays:									
Dental X-Rays      Indicate Minimum Copayment amount for Fluoride Treatment:      Yes      No      Select which combination of services are included in a single     cost per Office Visit:      Orial Exams      Prophylaxis (Cleaning)      Fluoride Treatment      Indicate Maximum Copayment amount for Dental X-Rays:      Indicate Maximum Copayment amount for Dental X-Rays:      Prophylaxis (Cleaning)      Fluoride Treatment      Indicate Maximum Copayment amount for Dental X-Rays:						Indicate Maximum Copayment amount for Prophylaxis (Cleaning):			
s there a combination of services included in a single cost per Office Visit?   Yes No Indicate Minimum Copayment amount for Fluoride Treatment: Indicate Maximum Copayment amount for Fluoride Treatment: Indicate Maximum Copayment amount for Fluoride Treatment: Indicate Maximum Copayment amount for Pluoride Treatment: Indicate Maximum Copayment amount for Pluoride Treatment: Indicate Maximum Copayment amount for Dental X-Rays: Indicate Maximum Copaymen									
C Yes       Indicate Maximum Copayment amount for Fluoride Treatment:         Select which combination of services are included in a single cost per Office Visit:       Indicate Maximum Copayment amount for Dental X-Rays:         □ Pra Exams       Indicate Minimum Copayment amount for Dental X-Rays:         □ Prophylaxis (Cleaning)       Indicate Maximum Copayment amount for Dental X-Rays:	is there a com		ervices included in	n a single cost per		Indicate Minimum Copayment amount for Fluoride Treatment:			
No     Indicate Maximum Copayment amount for Fluoride Treatment:       Select which combination of services are included in a single cost per Office Visit:     Indicate Maximum Copayment amount for Dental X-Rays:       Oral Exams     Indicate Minimum Copayment amount for Dental X-Rays:       Prophylaxis (Cleaning)     Indicate Maximum Copayment amount for Dental X-Rays:       Fluoride Treatment     Indicate Maximum Copayment amount for Dental X-Rays:									
Select which combination of services are included in a single cost per Office Visit: Oral Exams Prophylaxis (Cleaning) Fluoride Treatment Indicate Maximum Copayment amount for Dental X-Rays:						Indicate Maximum Copayment amount for Fluoride Treatment:			
cost per Office Visit:     Indicate Minimum Copayment amount for Dental X-Rays:       Oral Exams     Indicate Minimum Copayment amount for Dental X-Rays:       Prophylaxis (Cleaning)     Indicate Maximum Copayment amount for Dental X-Rays:					_				
Cral Exams     Prophylaxis (Cleaning)     Fluoride Treatment     Indicate Maximum Copayment amount for Dental X-Rays:			of services are inc	ciuded in a single		Indicate Minimum Consument amount for Dental X Rays			
Fluoride Treatment     Indicate Maximum Copayment amount for Dental X-Rays:									
indicate maximum copayment amount for Dental A-rays.			)			·			
						Indicate Maximum Copayment amount for Dental X-Rays:			
	Dental A-	ivays							

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authorizatio	n required?									
Yes No										
	quired for Prev	entive Dental Serv	vices?							
Yes No										
eventive Der	ntal Services N	lotes								
ote may inclu tegory. Do n	de additional i ot repeat infor	nformation to des mation captured in	cribe benefit in t n data entry.	his service						
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PBP Data Entry System - Section B-16, Contract X0001, Plan 001, S	Segment 000		- 🗆 ×
e Help			
Previous Next (Validate) Go T	• #16b Comprehensive Dental - Base 1	<b>.</b>	
CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Non-routine Services:	Select type of benefit for Diagnostic Services:	Select type of benefit for Restorative Services:
Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.	C Mandatory C Optional	C Mandatory C Optional	C Mandatory C Optional
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Is this benefit unlimited for Non-routine Services?	Is this benefit unlimited for Diagnostic Services?	Is this benefit unlimited for Restoration Services?
C Yes C No	C Yes C No, indicate number	C Yes C No, indicate number	C Yes C No, indicate number
Select enhanced benefits: Non-routine Services Diagnostic Services	Indicate number of visits for Non- routine Services:	Indicate number of visits for Diagnostic Services:	Indicate number of visits for Restorative Services:
Restorative Services Endodontics Periodontics	Select the Non-routine Services periodicity:	Select the Diagnostic Services periodicity:	Select the Restorative Services periodicity:
Extractions Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every two years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe

PBP Data Entry System - Section B-16, Contr Help			×
revious Next (Validate)	Go To: #16b Comprehensive Dental- Exit (No Validate)	Base 2	•
lect type of benefit for Endodontics:	Select type of benefit for Periodontics:	Select type of benefit for Extractions:	Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:
Mandatory Optional	C Mandatory C Optional	C Mandatory C Optional	C Mandatory C Optional
this benefit unlimited for Endodontics?	Is this benefit unlimited for Periodontics?	Is this benefit unlimited for Extractions?	Is this benefit unlimited for Prosthodontics, Other
Yes No, indicate number	C Yes C No, indicate number	C Yes C No, indicate number	Oral/Maxillofacial Surgery, Other Services?
ndicate number of visits for Endodontics:	Indicate number of visits for Periodontics:	Indicate number of visits for Extractions:	C No, indicate number
lect the Endodontics periodicity:	Select the Periodontics periodicity:	Select the Extractions periodicity:	Indicate number of visits for Prosthodontics, Oth Oral/Maxillofacial Surgery, Other Services:
Every three years Every two years Every two years Every year	C Every three years C Every two years C Every two years	C Every three years C Every two years C Every year	Select the Prosthodontics/Other Oral/Maxillofa Surgery/Other Services periodicity:
Every six months Every three months Other, Describe	C Every six months C Every three months C Other, Describe	C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year
			C Every six months C Every three months C Other, Describe

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there a services on the Malera Services on th	vice-specific Ma aximum Plan Bi under Prevent ecified amount ; y OR does it ap ork services only network and Ou aximum Plan Bi e Maximum Plan three years two years	aximum Plan Beni enefit Coverage ty ive Dental Catego ser period nefit Coverage an ply to both In-netv	efit Coverage an ype: ory 16a mount apply to 1 work and Out-of ices mount:	n-network	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  Yes No Select the Maximum Enrollee Out-of-Pocket Cost type: C Overed under Preventive Dental Category 16a Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: Select Maximum Enrollee Out-of-Pocket Cost periodici			

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s there an enrollee	Coinsurance?			Is there an enrollee Deductible?	
C Yes				C Yes	
C No				C No	
Select which Compr	ehensive Dental	Services have a	Coinsurance (Select		
hat apply):				Indicate Deductible Amount:	
Medicare-covere					
Non-routine Service Diagnostic Service					
Restorative Servi					
Endodontics	003				
Periodontics					
Extractions					
Prosthodontics,	Other Oral/Maxil	llofacial Surgery,	Other Services		
	Minimu	m Coinsurance	Maximum Coins	nce	
Medicare-covered B	enefits				
Non-routine Service	s [				
Diagnostic Services	Г				
-	1		I		
Restorative Services	- T				
Restorative Services	· 1				
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Endodontics	1				
Periodontics	Γ				
Extractions	Г				
	1				
Prosthodontics, Oth	er [				
Dral/Maxillofacial Su			1		
Other Services:					

C Yes         Nata apply:         Medicare-covered Benefits         Non-route Services         Bagnostic Services         Betorotics         Deriodontics         Other Oral/Maxillofacial Surgery, Other Services         Copayment Minimum         Copayment Minimum         Copayment Minimum         Copayment Minimum         Copayment Minimum         Copayment Services         Diagnostic Services         Periodontics         Other Control         Periodontics         Periodontics         Copayment Minimum         Copayment Services         Diagnostic Services         Periodontics         Prosthodontics Pyreyr,	le Help	System S	ection B-16, Contra		lan ee i, segin			
C No         Select which Comprehensive Dental Services have a Copayment (Select all that apply):         Medicare-covered Benefits         Diagnottic Services         Endodontics         Periodontics         Extractions         Copayment Minimum         Restorative Services         Diagnostic Services         Endodontics         Periodontics         Periodontics         Periodontics         Periodontics         Periodontics         Periodontics         Posthodontics         Copayment Minimum         Copayment Minimum         Copayment Maximum         Medicare-covered Benefits         Diagnostic Services         Endodontics         Periodontics         Periodontics         Periodontics         Periodontics         Periodontics         Periodontics         Prosthodontics         Post	Previous	Next	Exit	Exit (No Validate)	Go To:	#16b Comprehensive Dental - Base 5	•	
Yes         No         Select which Comprehensive Dental Services have a Copayment (Select all that apply):         Medicare-covered Benefits         Diagnostic Services         Restorative Services         Endodontics         Periodontics         Detropyment Minimum         Copayment Minimum         Restorative Services         Diagnostic Services         Diagnostic Services         Diagnostic Services         Diagnostic Services         Periodontics         Periodontics         Endodontics         Copayment Minimum         Copayment Maximum         Medicare-covered Benefits         Diagnostic Services         Diagnostic Services         Endodontics         Periodontics         Periodontics         Periodontics         Copayment Minimum								
Image: Services       Image: Services         Select which Comprehensive Dental Services have a Copayment (Select all that apply):         Image: Medicare-covered Benefits         Image: Diagnostic Services         Image: Diagnostic Services <td></td> <td>ee Copayme</td> <td>nt?</td> <td></td> <td></td> <td></td> <td></td> <td></td>		ee Copayme	nt?					
that apply): Medicare-covered Benefits Extractions Copayment Minimum Copayment Maximum Medicare-covered Benefits Diagnostic Services Copayment Minimum Copayment Maximum Medicare-covered Benefits Non-routine Services Diagnostic Services Restorative Services Endodontes Periodontics Periodontics Periodontics Periodontics Periodontics Prosthodontics, Other Oral Maxillofacial Surgery, Cher Services								
Medicare-covered Benefits	Select which Com that apply): Medicare-cov Non-routine S Diagnostic Se Restorative Se Endodontics Periodontics Extractions	ered Benefits ervices ervices ervices	5					
Non-routine Services		c	Copayment Minimur	m Cop	payment Maxim	num		
Diagnostic Services	Medicare-covered	d Benefits		1				
Restorative Services	Non-routine Servi	ices		]				
Endodontics Periodontics Extractions Prosthodontics, Other Oral/Maxillofacial Surgery,	Diagnostic Servic	ces		1				
Periodontics Extractions Prosthodontics, Other Oral/Maxillofacial Surgery,	Restorative Servi	ces		1				
Extractions Prosthodontics, Other Oral/Maxillofacial Surgery,	Endodontics			]				
Prosthodontics, Other Oral/Maxillofacial Surgery,	Periodontics			]				
Oral/Maxillofacial Surgery,	Extractions			]				
	Oral/Maxillofacial	Other I Surgery,		]				

Yes No a referral requir Yes No mprehensive I te may include tegory. Do not	red for Comp Dental Servic additional in	(Validate) prehensive Denta pres Notes formation to des nation captured in	cribe benefit in ti	nis service		
Yes No omprehensive I ote may include stegory. Do not i	red for Comp Dental Servic additional in	ces Notes nformation to des	cribe benefit in ti	nis service		
a referral requir Yes No omprehensive I ote may include itegory. Do not	Dental Servic	ces Notes nformation to des	cribe benefit in ti	nis service		
s a referral requir Yes No Comprehensive [ lote may include ategory. Do not	Dental Servic	ces Notes nformation to des	cribe benefit in ti	his service		
C Yes C No Comprehensive I Note may include category. Do not i	Dental Servic	ces Notes nformation to des	cribe benefit in ti	nis service		
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#### #17a Eye Exams – Base 1

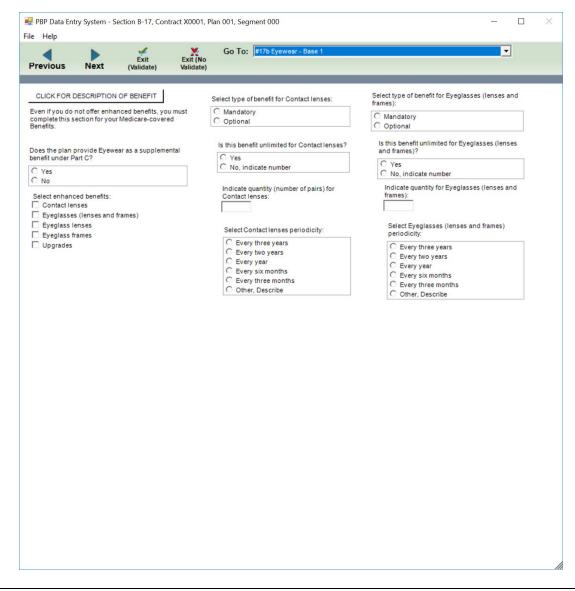
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Coverage amount?       Operation of Benefit information of Benefit for Other Service:       Operation of Coverage amount?       Operaveration of Coverage amount?       Operation o	Exit Exit (No	Go To: #17a Eye Exams - Base 1	•	
	Previous       Next       Exit (Validate)       Exit (No Validate)         CLICK FOR DESCRIPTION OF BENEFIT	Enter name of Other Service:          Select type of benefit for Other Service:         Mandatory         Optional         Is this benefit unlimited for Other Service?         Yes         No, indicate number         Indicate quantity for Other Service:         Select the Other Service periodicity:         Every three years         Every two years         Every year         Cevery three onths	Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes No Does the Maximum Plan Benefit Coverage amount apply to in-network services only OR does it apply to both In-network and Out-of-network services? C In-network services only Both In-network and Out-of-network services Indicate Maximum Plan Benefit Coverage amount: Select the Maximum Plan Benefit Coverage periodicity: C Every three years E Every year C Every three months E Very three months	C Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every three years C Every year C Every six months C Every three months

### #17a Eye Exams – Base 2

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Is there an enro	llee Coinsuran	ice?			Is there an enrollee Copayment?	Is there an enrollee Deductible?		
Select which Ey Medicare-co Routine Eye Other	vered Benefits Exams	a Coinsurance ( nce percentage fo			Select which Eye Exams have a Copayment (Select all that apply): Select which Eye Exams Routine Eye Exams Other Indicate Minimum Copayment amount for Medicare-covered Benefits:	Indicate Deductible Amount:		
Benefits:		nce percentage f			Indicate Maximum Copayment amount for Medicare-covered Benefits:			
		nce percentage f			Indicate Maximum Copayment amount for Routine Eye Exams:			
Indicate Minim	num Coinsurar	nce percentage fo	or Other Service		Indicate Minimum Copayment amount for Other Service:			
Indicate Maxim	mum Coinsura	nce percentage f	or Other Service	e:	Indicate Maximum Copayment amount for Other Service:			

# #17a Eye Exams – Base 3

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	n required?									
Yes No										
	quired for Eye I	Exams?								
Yes										
No										
Exams No		nformation to des	cribe benefit in t	his service						
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Exit Exit (No	Select type of benefit for Eyeglass frames:   Mandatory  Optional  Is this benefit unlimited for Eyeglass frames?  Yes No, indicate number  Indicate quantity for Eyeglass frames:  Select Eyeglass frames periodicity:  Every three years Every three years Every three years Every three months Every three months Other, Describe  Select type of benefit for Upgrades:  Mandatory Optional			

Previous Next (Validate)	Go To: #17b Eyewear - Base Exit (No Validate)	3	•
Sthere a service-specific Maximum Plan enefit Coverage amount? Yes No Select the Maximum Plan Benefit Coverage type: Covered under Eye Exams Category 17a Plan-specified amount per period Does the Maximum Plan Benefit Coverage amount apply to hon-network services only OR does it apply to both In- network and Out-of-network services? In-network services only Both In-network and Out-of-network services Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear? Yes No Indicate Combined Maximum Plan Benefit Coverage amount:	Select the Combined Maximum Plan Benefit Coverage periodicity: Cevery three years Every two years Every two years Cevery six months Coverage amount: Conter, Describe Select the type of Eyewear with individual Max Plan Benefit Coverage amount: Contact lenses Eyeglass ses (lenses and frames) Eyeglass lenses Select the Individual Maximum Plan Benefit Coverage periodicity for Contact lenses: Select the Individual Maximum Plan Benefit Coverage periodicity for Contact lenses: Cevery three years Every two years Every three months Cevery the months Cevery the periodicity for Contact lenses: Cevery two years Cevery two months Cevery the months Cother, Describe	Indicate Max Plan Benefit Coverage amount for Eyeglasses (lenses and frames): Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglasses (lenses and frames): Every two years Every two years Very two years Other, Describe Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglass lenses: Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglass lenses: Every tree years Every tree years Every six months Every six months Other, Describe	Indicate Max Plan Benefit Covers amount for Eyeglass frames: Select the Individual Maximum P Benefit Coverage periodicity for Eyeglass frames: C Every two years C Every two years C Every six months C Other, Describe Indicate Max Plan Benefit Covers amount for Upgrades: Select the Individual Maximum Plan Benefit Coverage periodicit for Upgrades: C Every three years C Every three years C Every six months C Every six months C Every three months C Other, Describe

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Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes C No	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	Indicate Minimum Coinsurance percentage for Eyeglass frames:
Select the Maximum Enrollee Out-of-Pocket Cost type: Covered under Eye Exams Category 17a Plan-specified amount per period	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Maximum Coinsurance percentage for Eyeglass frames:
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Minimum Coinsurance percentage for Contact lenses:	Indicate Minimum Coinsurance percentage for Upgrades:
Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	Indicate Maximum Coinsurance percentage for Contact lenses: Indicate Minimum Coinsurance percentage for Eyeglasses (lenses and frames):	Indicate Maximum Coinsurance percentage for Upgrades:
Is there an enrollee Coinsurance? C Yes C No Select which Eyewear Benefits have a Coinsurance (Select all that	Indicate Maximum Coinsurance percentage for Eyeglasses (lenses and frames):	
apply): Medicare-covered Benefits Contact lenses Eyeglasses (lenses and frames) Eyeglass lenses Eyeglass frames Upgrades	Indicate Minimum Coinsurance percentage for Eyeglass lenses:	

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Is there an enro	llee Deductibl	e?			Indicate Minimum Copayment amount for Contact lenses:	Indicate Minimum Copayment amount for Eyeglass frames:	
C Yes C No							
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Indicate Dedu	ctible Amount				Indicate Maximum Copayment amount for Contact lenses:	Indicate Maximum Copayment amount for Eyeglass frames:	
1							
Is there an enro	llee Copayme	nt?			Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	Indicate Minimum Copayment amount for Upgrades:	
C Yes							
C No							
Select which E apply):	yewear Benef	its have a Copayn	nent (Select all	that	Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	Indicate Maximum Copayment amount for Upgrades:	
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Contact len					Indicate Minimum Consument amount for Eventors langer		
Eyeglasses		frames)			Indicate Minimum Copayment amount for Eyeglass lenses:		
Eyeglass fr							
Upgrades					Indicate Maximum Copayment amount for Eyeglass lenses:		
Indicate Minim	um Conavmer	nt amount for Medi	care-covered				
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CLICK FOR DESCRIPTION OF BENEFIT Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits. Does the plan provide Hearing Exams as a supplemental benefit under Part C? C Yes C No Select enhanced benefits: Routine Hearing Exams	Select Routine Hearing Exams periodicity:  C Every three years Every year Every six months Every three months C Every scribe  Select type of benefit for Fitting/Evaluation for Hearing Aid: C Mandatory C Optional  Is this benefit unlimited for Fitting/Evaluation for			
Fitting/Evaluation for Hearing Aid Select type of benefit for Routine Hearing Exams: C Mandatory C Optional Is this benefit unlimited for Routine Hearing Exams?	Hearing Aid?			
C Yes C No, indicate number Indicate number for Routine Hearing Exams:	Select Fitting/Evaluation for Hearing Aid periodicity: C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe			

	Go To: #18a Hearing Exams - Base 2 lidate)	<b>_</b>	
s there a service-specific Maximum Plan Benefit Soverage amount?  Yes No Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply both In-network and Out-of-network services? Indicate Maximum Plan Benefit Coverage amount: Select the Maximum Plan Benefit Coverage amount: C Every three years C Every year C Every two years C Every three months O Other, Describe Is there an enrollee Deductible? Yes No Indicate Deductible Amount:	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes         Indicate Maximum Enrollee Out-of-Pocket Cost amount:         Select Maximum Enrollee Out-of-Pocket Cost periodicity:         Every three years         Every three years         Every three months         Other, Describe         Is there an enrollee Consurance?         Yes         No         Select which Hearing Exam Benefits have a Coinsurance (Select all that apply):         Medicare-covered Benefits         Fitting/Evaluation for Hearing Aid	Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits: Indicate Minimum Coinsurance percentage for Routine Hearing Exams: Indicate Maximum Coinsurance percentage for Routine Hearing Exams: Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:	

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there an enro	ollee Copaym	ent?			Is authorization required?			
Yes					C Yes C No			
Select which		m Benefits have a	Copayment (S	elect all that a				
	-covered Ber Hearing Exam				O Yes			
	aluation for H				C No			
Indicate Min	imum Copayr	ment amount for M	edicare-covere	d Benefits:				
Indicate Max	cimum Copay	ment amount for M	edicare-covere	ed Benefits:				
Indicate Min	imum Copayr	ment amount for R	outine Hearing	Exams:				
Indicate Max	cimum Copay	ment amount for R	outine Hearing	Exams:				
Indicate Min	imum Copayr	ment amount for Fit	ting/Evaluation	for Hearing	d:			
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earing Exams Notes ote may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. otes:	revious	Next	Exit (Validate)	Exit (No Validate)	0010.				
ote may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.									
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CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Hearing Aids as a supplemental benefit under Part C? Yes No Select enhanced benefits: Hearing Aids (all types) Hearing Aids - Outer Ear Hearing Aids - Over the Ear	Select type of benefit for Hearing Aids (all types):          Mandatory         Optional         Is this benefit unlimited for Hearing Aids (all types)?         Yes         No, indicate number         Indicate quantity for Hearing Aids (all types):         Select Hearing Aids (all types) periodicity:         Every three years         Every year         Every year         Every three months         Other, Describe	Select type of benefit for Hearing Aids - Inner Ear: Mandatory Optional Is this benefit unlimited for Hearing Aids - Inner Ear? Yes No. indicate number Indicate quantity for Hearing Aids - Inner Ear: Select Hearing Aids - Inner Ear periodicity: Every two years Every year Very stree months Cother, Describe	Select type of benefit for Hearing Aids - Outer Ear: Mandatory Optional Is this benefit unlimited for Hearing Aids - Outer E No, indicate number Indicate quantity for Hearing Aids - Outer Ear: Select Hearing Aids - Outer Ear periodicity: Every three years Every year Every year Every year Other, Describe

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Select type of benefit for Hearing Aids - Over the Ear: Optional Is this benefit unlimited for Hearing Aids - Over the Ear? Oregonal Is this benefit unlimited for Hearing Aids - Over the Ear? Oregonal Indicate number Indicate quantity for Hearing Aids - Over the Ear: Select Hearing Aids - Over the Ear periodicity: Crevery three years Crevery three years Crevery year Crevery six months Crevery year Selection the Service-specific Maximum Pian Benefit Coverage amount? Yes No	Does the Maximum Plan Benefit Coverage Amount apply per ear of or both ears combined	

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	Indicate Minimum Coinsurance percentage for Hearing Aids (all types): Indicate Maximum Coinsurance percentage for Hearing Aids - Inner Ear: Indicate Minimum Coinsurance percentage for Hearing Aids - Inner Ear: Indicate Minimum Coinsurance percentage for Hearing Aids - Outer Ear: Indicate Minimum Coinsurance percentage for Hearing Aids - Outer Ear:	Indicate Minimum Coinsurance percentage for Hearing Aids - Over the Ear:

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s authorization	n required?								
O Yes O No									
	uired for Hear	ing Aids?							
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learing Aids N	lotes								
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le Help	Go To: #20 Outpatient Dru	gs - Base 1	-	
Exit	Exit (No Validate)		_	
CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Outpatient Drugs as a supplemental benefit under Part C? Yes No Select type of benefit: Ondete the number of drug groupings that are offered: O C C C C C C C C C C C C C C C C C C	Is there a Maximum Plan Benefit Coverage amount for drugs? C Yes Indicate type of Maximum Plan Benefit Coverage: All drug groups covered by plan Combination of drug groups Individual drug groups Is the Maximum Plan Benefit Coverage net of the enrollee copay? C Yes No Indicate Maximum Plan Benefit Coverage periodicity for drugs: Annually Semi-annually Quarterly Monthly Other, Describe	Indicate Max Plan Benefit Coverage amount annually for drugs: Indicate Max Plan Benefit Coverage amount semi- annually for drugs: Indicate Max Plan Benefit Coverage amount quarterly for drugs: Indicate Max Plan Benefit Coverage amount monthly for drugs:		

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Can any unused amount	s be carried forward to	the next period	d within the	Indicate Max Plan Benefit Coverage amount annually for combination of		
contract period?				drug groups:		
C Yes C No						
Select what combination Benefit:	of drug groups are in	cluded in the Ma	aximum Plan	Indicate Max Plan Benefit Coverage amount semi-annually for combination of drug groups:		
Group 1 Group 2				1		
Group 3				Indicate Max Plan Benefit Coverage amount quarterly for combination of		
Group 4				drug groups:		
Group 5						
Indicate Maximum Plan B drug groups: Annually	Benefit Coverage perio	dicity for combi	nation of	Indicate Max Plan Benefit Coverage amount monthly for combination of drug groups:		
Semi-annually						
Quarterly						
Monthly				Indicate Max Plan Benefit Coverage amount for Other for combination of drug groups:		
Other, Describe						

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Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached? Yes No Indicate the selected group(s) for which the Maximum Plan Benefit Coverage is waived: Group 1 Group 2 Group 3 Group 4 Group 5	Indicate Maximum Enrollee Out-of-Pocket Cost amount:          Select the Maximum Enrollee Out-of-Pocket Cost periodicity:         C       Every year         C       Every six months         C       Every three months         Is there an enrollee Coinsurance for Medicare-covered Benefits?         C       Yes         No         Select which Medicare-covered Outpatient Drugs have a Coinsurance	
Does the enrollee incur a cost in addition to the Coinsurance or Copay for selecting a higher priced drug when a less expensive drug is available? C Yes C No Is there a Maximum Enrollee Out-of-Pocket Cost? C Yes C No	(Select all that apply): Medicare Part B Chemotherapy/Radiation Drugs Other Medicare Part B Drugs Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs: Indicate Maximum Coinsurance percentage for Medicare Part B	
Select what combination of drug groups applies for Maximum Enrollee Out-of-Pocket Cost: Group 1 Group 2 Group 3 Group 4 Group 5 Medicare Covered Benefits	Chemotherapy/Radiation Drugs: Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs: Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:	

Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#20 Outpatient Drugs - Base 4	-	
Group 1 Group 2 Group 3 Group 3 Group 4 Group 5 Medicare Indicate Dec Sthere an enro Yes No Select which (Select all th	Covered Ber luctible amou llee Copaym Medicare-co at apply): Part B Chem	of drug groups app nefits nt: ent for Medicare-c vered Outpatient I otherapy/Radiatio	covered Benefits Drugs have a C	5?	Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs: Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs: Indicate Minimum Copayment for other Medicare Part B Drugs: Indicate Maximum Copayment for other Medicare Part B Drugs: Is authorization required? Yes No		

### #20 Outpatient Drugs – Notes

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ote may inclu	de additional i	nformation to des	cribe benefit in t	this service	ategory. Do	notrepeatint	formation cap	tured in data	entry.			
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# #20 Outpatient Drugs – Group 1 – Base 1

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elect a label for Group 1:  Select the drug type(s) covered for Group 1:  Generic	Indicate Maximum Plan Benefit Coverage annual amount for Group 1: Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1:		
Preferred Brand Brand there a Maximum Plan Benefit Coverage amount for Group 1? Yes	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:		
No dicate Maximum Plan Benefit Coverage for Group 1 periodicity: Annually	Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:		
Semi-annually Quarterly Monthly Per Prescription Other, Describe	Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1:		
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:		

# #20 Outpatient Drugs – Group 1 – Base 2

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#20 Outpatient	Drugs - Group 1 -	- Base 2		×	[	
Designated HMO-Owned Mail Order Other, Descr Is there an enro	Retail Pharma d Pharmacy ribe	rugs can be acqui acy nce for Group 1?	red:	-		payment for Grou	up 1?				
C Yes C No				O Ye							
Indicate Coins Pharmacy:	urance perce	ntage for Group 1	Designated Reta		ate Copayment a gnated Retail Pha	amount for Group armacy:		Jp to a day supply covered for Group 1 Designated Retail Pharmacy			
Indicate Coins Pharmacy:	urance perce	ntage for Group 1	HMO-Owned		ate Copayment a Owned Pharmac	mount for Group cy:	51 I	Up to a day supply covered for Group 1 HMO-Owned Pharmacy:			
Indicate Coinsi	urance perce	ntage for Group 1	Mail Order:		ate Copayment a Drder:	mount for Group	51 [	Up to a day supply covered for Group 1 Mail Order:	6		
Indicate Coins	urance perce	ntage for Group 1	Other:	Indic Othe		amount for Group	p 1 1	Up to a day supply covered for Group 1 Other:			
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# #20 Outpatient Drugs – Group 2 – Base 1

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Select a label for Group 2:	Indicate Maximum Plan Benefit Coverage annual amount for Group 2:			
Select the drug type(s) covered for Group 2: Generic Preferred Brand Brand	Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2:			
s there a Maximum Plan Benefit Coverage amount for sroup 2? Yes	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:			
C No ndicate Maximum Plan Benefit Coverage for Group 2 eriodicity: Annually Semi-annually Quarterly	Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:			
Monthly Per Prescription Other, Describe	Indicate Maximum Plan Benefit Coverage amount per prescription for Group 2:			
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 2:			

# #20 Outpatient Drugs – Group 2 – Base 2

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	Go To: #20 Outpatient Drugs - Group 2 - Base 2 Exit (No alidate)		•	
Select from where Group 2 Drugs can be acquired Designated Retail Pharmacy HM0-Owned Pharmacy Mail Order Other, Describe Is there an enrollee Coinsurance for Group 2? Yes No Indicate Coinsurance percentage for Group 2 for HM0-Owned Pharmacy: Indicate Coinsurance percentage for Group 2 for HM0-Owned Pharmacy: Indicate Coinsurance percentage for Group 2 for Mail Order: Indicate Coinsurance percentage for Group 2 for Other:	Designated Retail Pharmacy: Design	Owned Pharmacy: a day supply covered for Group 2 Order: a day supply covered for Group 2		

# #20 Outpatient Drugs – Group 3 – Base 1

e Help						7	
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elect a label fo	or Group 3:		•	Indicate Maximum Plan Benefit Coverage annual amount for Group 3:			
elect the drug Generic Preferred Br Brand		ed for Group 3:		Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 3:			
Group 3?	mum Plan Ben	efit Coverage amo	ount for	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 3:			
Yes No ndicate Maxim eriodicity:	um Plan Bene	fit Coverage Grou	up 3	Indicate Maximum Plan Benefit Coverage monthly amount for Group 3:			
Annually Semi-annually Quarterly Monthly Per Prescription			Indicate Maximum Plan Benefit Coverage amount per prescription for Group 3:				
Other, Desc	ribe			Indicate Maximum Plan Benefit Coverage amount for Other for Group 3:			

# #20 Outpatient Drugs – Group 3 – Base 2

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Designated HMO-Owne Mail Order Other, Desc s there an enro Yes No	Retail Pharma d Pharmacy ribe ollee Coinsura	rugs can be acqu Iccy nce for Group 3? ntage for Group 3		Is there an enrollee Copayment for Group 3? C Yes C No Indicate Copayment amount for Group 3 Designated Retail Pharmacy:	Up to a day supply covered for Group 3 Designated Retail Pharmacy:		
Indicate Coin: Pharmacy:	surance perce	ntage for Group 3	HMO-Owned	Indicate Copayment amount for Group 3 HMO-Owned Pharmacy:	Up to a day supply covered for Group 3 HMO-Owned Pharmacy:		
Indicate Coins	surance perce	ntage for Group 3	Mail Order:	Indicate Copayment amount for Group 3 Mail Order:	Up to a day supply covered for Group 3 Mail Order:		
Indicate Coins	surance perce	ntage for Group 3	Other:	Indicate Copayment amount for Group 3 Other:	Up to a day supply covered for Group 3 Other:		

# #20 Outpatient Drugs – Group 4 – Base 1

Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #20 Outpatient Drugs - Group 4 - Base 1	•		
Frevious	MEAL	(validate)	validate)		-	-	
Select a label fo	or Group 4:		•	Indicate Maximum Plan Benefit Coverage annual amount for Group 4:			
Select the drug Generic Preferred Bi Brand		ed for Group 4:		Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 4:			
Is there a Maxi Group 4? C Yes C No	mum Plan Ber	efit Coverage amo	ount for	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 4:			
		fit Coverage Grou	ip 4:	Indicate Maximum Plan Benefit Coverage monthly amount for Group 4:			
Monthly Per Prescrip Other, Desc				Indicate Maximum Plan Benefit Coverage amount per prescription for Group 4:			
				Indicate Maximum Plan Benefit Coverage amount for Other for Group 4:			

# #20 Outpatient Drugs – Group 4 – Base 2

Republic Contract X0001, Plan 001	-		×	
File Help Previous Next Exit Exit Exit (No Validate) Go	To: #20 Outpatient Drugs - Group 4 - Base 2	•	[	
Select from where Group 4 Drugs can be acquired: Designated Retail Pharmacy HMO-Owned Pharmacy Mail Order Other, Describe Is there an enrollee Coinsurance for Group 4? Is the Yes Yes No Indicate Coinsurance percentage for Group 4 Designated Retail Pharmacy: Indicate Coinsurance percentage for Group 4 HMO-Owned Indicate Coinsurance percentage for Group 4 Mail Order:	to cate Copayment amount for Group 4 Up to a day supply covered Group 4 Designated Retail Pharmacy: Cate Copayment amount for Group 4 Up to a day supply covered Group 4 HMO-Owned Pharmacy: Cate Copayment amount for Group 4 Up to a day supply covered Group 4 Mail Order: Cate Copayment amount for Group 4 Up to a day supply covered Group 4 Mail Order: Cate Copayment amount for Group 4 Up to a day supply covered Group 4 Mail Order: Cate Copayment amount for Group 4 Up to a day supply covered Group 4 Mail Order: Cate Copayment amount for Group 4 Up to a day supply covered Group 4 Mail Order: Cate Copayment amount for Group 4 Up to a day supply covered Cate Copayment amount for Group 4 Up to a day supply covered Cate Copayment amount for Group 4 Up to a day supply covered Cate Copayment amount for Group 4 Up to a day supply covered Cate Copayment amount for Group 4 Up to a day supply covered Cate Copayment amount for Group 4 Up to a day supply covered Cate Copayment amount for Group 4 Up to a day supply covered Cate Copayment amount for Group 4 Up to a day supply covered Cate Copayment amount for Group 4 Up to a day supply covered Cate Copayment amount for Group 4 Up to a day supply covered Cate Copayment amount for Group 4 Up to a day supply covered Cate Copayment amount for Group 4 Up to a day supply covered Cate Copayment amount for Group 4 Up to a day supply covered Cate Copayment Amount for Group 4 Up to a day supply covered Cate Copayment Amount for Group 4 Up to a day supply covered Cate Copayment Amount for Group 4 Up to a day supply covered Cate Copayment Amount for Group 4 Up to a day supply covered Cate Copayment Amount for Group 4 Up to a day supply covered Cate Copayment Amount for Group 4 Up to a day supply covered Cate Copayment Amount for Group 4 Up to a	acy: for for		

# #20 Outpatient Drugs – Group 5 – Base 1

e Help					 [	
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #20 Outpatient Drugs - Group 5 - Base 1		
Select a label f	or Group 5:			Indicate Maximum Plan Benefit Coverage annual amount for Group 5:		
Select the drug Generic Preferred B Brand		ed for Group 5:		Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 5:		
s there a Maxi Group 5?	mum Plan Ber	efit Coverage am	ount for	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5:		
O No		fit Coverage for G	Group 5	Indicate Maximum Plan Benefit Coverage monthly amount for Group 5:		
Quarterly Monthly Per Prescri Other, Desc	otion			Indicate Maximum Plan Benefit Coverage amount per prescription for Group 5:		
				Indicate Maximum Plan Benefit Coverage amount for Other for Group 5:		

# #20 Outpatient Drugs – Group 5 – Base 2

PBP Data Entry System - Section B-20, Contract X000 Help	1, Plan 001, Segment 000			0
revious Next (Validate) Valida		Base 2	•	
elect from where Group 5 Drugs can be acquired: Designated Retail Pharmacy HMO-Owned Pharmacy Mail Order Other, Describe there an enrollee Coinsurance for Group 5? Yes	Is there an enrollee Copayment for Group 5?			
No ndicate Coinsurance percentage for Group 5 Designated Retail Pharmacy:	C No Indicate Copayment amount for Group 5 Designated Retail Pharmacy:	Up to a day supply covered for Group 5 Designated Retail Pharmacy:		
ndicate Coinsurance percentage for Group 5 HMO- wined Pharmacy:	Indicate Copayment amount for Group 5 HMO-Owned Pharmacy:	Up to a day supply covered for Group 5 HMO-Owned Pharmacy:		
ndicate Coinsurance percentage for Group 5 Mail Ord	Indicate Copayment amount for Group 5 Mail Order:	Up to a day supply covered for Group 5 Mail Order:		
ndicate Coinsurance percentage for Group 5 Other:	Indicate Copayment amount for Group 5 Other:	Up to a day supply covered for Group 5 Other:		

#### #20 Home Infusion Bundled Services

💀 PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000	_	$\times$
File Help		
Previous Next (Validate) Exit (No Validate) Go To: #20 Home Infusion Bundled Services	-	
Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?		
O Yes O No		
If you select 'Yes' to 'Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?', you must indicate these specific medications in a flat file which must be uploaded through the Formulary Submission Module by Friday, June 5, 2020 at 11:59 am Eastern Time. You must also ensure that your benefit includes not only the home infusion drug, but any services and supplies associated with the home infusion drug's administration.		
If your organization elects to provide Part D home infusion drugs as part of a bundled service then those services must be provided at \$0 cost sharing. As described in the CY 2010 Call Letter this waiver is conditioned on the application of zero cost sharing for the bundle of home infusion services provided under a supplemental benefit.		
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